[Your Name/Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Payer Name]
[Appeals Department Address]
[City, State, Zip Code]

RE: Appeal for Reconsideration of Denied Claim
Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy Number: [Policy ID]
Claim Number: [Claim Number]
Date of Service: [DOS]

To Whom It May Concern:

This letter is a formal appeal regarding the denial of the Evaluation and Management (E/M) service provided on the date referenced above. The claim was denied on the basis that the E/M service was bundled into a procedure performed on the same day.

We are requesting a reconsideration based on the correct application of **Modifier 25**. Per CPT guidelines, Modifier 25 is used to indicate that on the day a procedure or service was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

Clinical Justification:

- The patient presented for: [Reason for visit/Chief complaint].
- The separate E/M service (CPT [E/M Code]) was necessary to: [Briefly explain: e.g., evaluate a new problem, stabilize a chronic condition, or decide the need for the procedure].
- The procedure performed was: [CPT Code for procedure].

The attached medical documentation clearly demonstrates that the E/M service met the criteria for being "significant and separately identifiable." The work performed for the E/M service was distinct from the work required for the procedure itself.

We respectfully request that you overturn the initial denial and process this claim for full payment. If you require further information, please contact our office at [Phone Number].

Sincerely,

[Signature]
[Printed Name and Title]

Enclosures: Copy of original claim, EOB, and medical records for [Date of Service].