[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Insurance Company Name]
[Appeals Department]
[P.O. Box / Address]
[City, State, Zip Code]

RE: Appeal of Claim Denial
Patient Name: [Patient Name]
Member ID: [ID Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]

To Whom It May Concern,

I am writing to formally appeal the denial of the above-referenced claim. The reason provided for the denial was the omission of a physician's signature on the required documentation.

Please find attached the corrected documentation, which now includes the necessary physician signature and credentials. This document confirms the medical necessity of the services provided on [Date of Service].

I request that you reconsider this claim for payment based on the enclosed completed documentation. If any further information is required to process this appeal, please contact me directly at [Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
- Copy of Denial Letter
- Signed Medical Record/Order
- [Any additional supporting documents]