

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

[Date]

[Insurance Company Name]
[Appeals Department]
[Street Address]
[City, State, Zip Code]

RE: Appeal of Claim Denial

Patient Name: [Patient Full Name]
Subscriber ID: [Insurance ID Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
Denial Reason: Incomplete Patient Intake Documentation

To Whom It May Concern,

This letter is a formal appeal regarding the denial of the above-referenced claim. The claim was denied due to missing or incomplete intake documentation.

Enclosed with this letter, please find the comprehensive intake records required to process this claim, including:

- Completed and signed Patient Registration Form
- Signed Consent for Treatment
- Assignment of Benefits Form
- [List any other missing documents, e.g., Referral, Medical History Form]

The attached documentation provides the necessary information to verify patient eligibility and authorization for the services rendered. We believe this fulfills the requirements for claim adjudication.

We request that you review this additional information and re-process the claim for payment. If any further information is required, please contact our office at [Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Title/Position]

Enclosures: [List of attached documents]