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

[Date]

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

RE: Retroactive Appeal for Claim #[Claim Number]
Date of Service: [Date of Service]
Provider Name: [Name of Clinic/Doctor]

To the Appeals Department,

I am writing to formally appeal the denial of coverage for emergency services received at [Clinic Name] on [Date]. The claim was denied on the basis that the facility is not a covered provider or is out-of-network. I am requesting a retroactive exception for these services due to the emergency nature of my medical condition.

On the date of service, I experienced [Briefly describe the emergency symptoms, e.g., severe chest pain, sudden loss of consciousness]. Due to the severity and sudden onset of these symptoms, I believed that any delay in seeking medical attention would result in a serious threat to my health. [Clinic Name] was the nearest medical facility capable of providing immediate stabilization.

According to the "Prudent Layperson Standard," an emergency is defined as a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health. My situation met this criteria.

Enclosed please find the following supporting documentation:

- Medical records from the visit detailing the emergency symptoms.
- A copy of the original Explanation of Benefits (EOB).
- [Optional: A letter from the treating physician regarding the urgency of care].

I request that you reconsider this claim and process it at the in-network benefit level as a medical exception. Please notify me of your decision in writing within the required statutory timeframe.

Sincerely,

[Your Signature]

[Your Printed Name]