

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

[Date]

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

RE: Retroactive Authorization Appeal

Patient Name: [Patient Full Name]
Member ID Number: [ID Number]
Group Number: [Group Number]
Claim Number: [Claim Number]
Date of Service: [MM/DD/YYYY]
Provider Name: [Doctor/Facility Name]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for the services provided on [Date of Service]. The reason for the denial was cited as "lack of prior authorization." I am requesting a retroactive authorization due to the late discovery of active insurance coverage.

At the time services were rendered, I was unaware that my coverage with [Insurance Company Name] was active. It was only after the medical encounter that I received notification that my policy was retroactively effective to [Policy Start Date]. Consequently, neither the healthcare provider nor I were able to request the necessary prior authorization before the services were performed.

Enclosed, please find the following documentation to support this appeal:

- A copy of the denial letter/Explanation of Benefits (EOB).
- Proof of retroactive enrollment or late notification of coverage.
- Clinical notes and medical records confirming the medical necessity of the procedure/service.
- A letter of medical necessity from my treating physician.

Given that the service was medically necessary and that the insurance information was unavailable through no fault of the provider, I respectfully request that you review this claim for retroactive authorization and process payment accordingly.

Thank you for your time and reconsideration. I look forward to your written response within the standard timeframe.

Sincerely,

[Signature]

[Printed Name]