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

[Date]

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

RE: Retroactive Authorization Appeal
Patient Name: [Patient Name]
Member ID Number: [Member ID]
Claim Number: [Claim Number (if applicable)]
Date(s) of Service: [Dates of Service]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for services provided on [Dates of Service]. The request for authorization was originally denied because prior authorization was not obtained. However, I am requesting a retroactive authorization based on the recent retroactive approval of my Medicaid eligibility.

At the time the services were rendered, my Medicaid application was still pending. My Medicaid coverage has since been approved with an effective start date of [Retroactive Effective Date], which covers the dates of service mentioned above. Because my eligibility was backdated, it was impossible to provide an active Medicaid ID or obtain prior authorization at the time of the appointment.

Please find the following documents enclosed to support this appeal:

- A copy of the Medicaid Approval Letter showing the retroactive effective date.
- A copy of the original claim denial.
- Medical records related to the service (if applicable).

Since Medicaid is now my primary payer for the period in which these services occurred, I request that you process a retroactive authorization and reprocess the claim for payment.

Thank you for your time and for reconsidering this matter. I look forward to your written response within the required timeframe.

Sincerely,

[Signature]
[Printed Name]