[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 Name]
Member ID: [Member 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 coverage for services provided by [Provider/Facility Name] on [Date of Service]. This request is for a retroactive authorization due to an unexpected provider network transition that occurred during my course of treatment.

The denial was based on the provider being out-of-network. However, I was not properly notified of the network change prior to receiving services. At the time the appointment was scheduled, I believed in good faith that the provider remained in-network. This transition created a disruption in my continuity of care for [Condition/Reason for Treatment].

I am requesting a retroactive authorization and that this claim be processed at the in-network benefit level for the following reasons:

- Lack of timely notification regarding the provider's change in network status.
- Maintaining continuity of care for an ongoing medical condition.
- [Optional: Mention any emergency circumstances or lack of alternative providers].

Attached you will find documentation supporting this appeal, including [List attachments: medical records, previous authorization, or correspondence].

Please review this case and notify me of your decision within the required timeframe. Thank you for your time and consideration.

Sincerely,

[Your Signature]
[Your Printed Name]