

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

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

**RE: Appeal for Retroactive Authorization**

Patient Name: [Patient Full Name]  
Date of Birth: [MM/DD/YYYY]  
Member ID: [ID Number]  
Claim Number: [Claim Number, if applicable]  
Date of Service: [Date Service was Rendered]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for the services provided on [Date of Service]. This request is for a retroactive authorization due to an unavoidable clerical oversight.

The services provided were medically necessary for the patient's health and well-being. However, due to an administrative error in our [billing/scheduling] department, the required prior authorization was not submitted before the procedure took place. This was a human error and does not reflect the clinical necessity of the treatment.

Attached to this letter, please find the clinical documentation supporting the medical necessity of the treatment, as well as a brief explanation of the internal clerical error that occurred. We have since implemented corrective measures to ensure this oversight does not happen again.

We kindly request that you review this appeal and grant a retroactive authorization so that the claim may be processed for payment. Thank you for your time and consideration of this matter.

Sincerely,

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