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

[Date]

[Payer Name]
[Appeals Department Address]
[City, State, Zip Code]

RE: Appeal for Duplicate Claim Denial

Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy Number: [Member ID]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
Billed Amount: [Amount]

To Whom It May Concern,

This letter is a formal appeal regarding the denial of the above-referenced claim, which was denied as a "duplicate claim." We believe this denial is in error and request a formal review of the charges.

The services provided on [Date of Service] are not duplicates. They represent separate and distinct services because:

- [Option 1: The services were performed at different times on the same day.]
- [Option 2: The services involved different anatomical sites/locations.]
- [Option 3: This is a corrected claim submitted to replace a previous filing.]
- [Option 4: Multiple units of the same code were required for the specific treatment.]

Attached you will find the following supporting documentation:

- Medical Records/Progress Notes
- Operative Report (if applicable)
- CMS-1500 or UB-04 Form

Please reprocess this claim for payment. If you require additional information, please contact [Contact Name] at [Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name/Title]