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

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

RE: Appeal for Duplicate Claim Denial
Patient Name: [Patient Name]
Member ID: [Member ID]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
Total Billed Amount: [Amount]

To Whom It May Concern,

This letter is a formal appeal regarding the denial of the above-referenced claim. The claim was denied as a "duplicate"; however, we are requesting a reconsideration as these charges represent a separate and distinct encounter/service performed on the same day.

Please note the following details regarding the services provided:

- The services were performed at different times: [Time 1] and [Time 2].
- The services were performed for different clinical indications: [Brief Reason].
- Modifier [e.g., 59, 76, or 91] was utilized to indicate a distinct procedural service or repeat procedure.

Enclosed you will find the clinical documentation and medical records which support that these are separate encounters and not a duplicate submission of the same service.

We request that you re-process this claim for payment. If you require further information, please contact [Contact Name] at [Phone Number].

Sincerely,

[Signature]
[Typed Name]
[Title]

Enclosures: [List documents, e.g., Progress Notes, Encounter Forms, Original EOB]