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

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

RE: Appeal for Duplicate Claim Denial

Patient Name: [Patient Full Name]
Member ID: [Member ID Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]

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" service. We are requesting a redetermination based on the fact that these services were performed on distinct anatomical sites during the same encounter.

The following codes were billed:

- **CPT Code [Code 1]:** Performed on [Specific Anatomical Site A]
- **CPT Code [Code 2]:** Performed on [Specific Anatomical Site B]

Although these procedures share the same CPT code, they represent separate and distinct surgical sites/lesions. We have appended the appropriate modifier (e.g., Modifier 59, XS, or anatomical modifiers such as RT/LT) to indicate that these were not duplicate billings but separate procedures.

Attached please find the operative report and clinical notes highlighting the different locations treated. We request that you re-process this claim for full payment.

Thank you for your prompt attention to this matter. If you require further information, please contact [Name] at [Phone Number].

Sincerely,

[Your Signature]
[Typed Name and Title]

Enclosures: Operative Report, Clinical Notes, Original Claim Form