head>

[Your Name/Practice Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]
[Date]

[Insurance Company Name]
[Appeals Department]
[Address Line 1]
[City, State, Zip Code]

RE: Appeal of Duplicate Claim Denial

Patient Name: [Patient Name]
Member ID: [Member ID Number]
Date of Service: [Date of Service]
Claim Number: [Claim Number]
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 service"; however, we believe this denial is in error.

While the patient may have received services on the same date, this claim represents a distinct encounter performed by a different provider. Specifically:

- **Rendering Provider:** [Name of Provider]
- **Provider NPI:** [NPI Number]
- **Provider Specialty:** [Specialty]

The services provided were medically necessary and independent of any other services rendered to the patient on that day by other practitioners. Please review the attached medical documentation which details the unique nature of this encounter and the specific provider who rendered the care.

We kindly request that you reprocess this claim for payment. If you require any additional information, please contact our office at [Phone Number].

Sincerely,

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

Enclosures:
- Copy of Remittance Advice/Denial
- Medical Records/Chart Notes for Date of Service
- Provider Credentials/NPI Verification