[Your Name/Organization Name]
[Tax ID Number]
[NPI Number]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

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

RE: Appeal of Duplicate Claim Denial

Patient Name: [Patient Name]
Member ID: [Subscriber ID]
Claim Number: [Original Claim Number]
Date of Service: [Date of Service]
Total Billed Amount: $[Amount]

To Whom It May Concern,

I am writing to formally appeal the denial of the above-referenced claim, which was denied as a "duplicate" of a previously processed claim.

Upon review of our records, this claim is not a duplicate. While the provider and patient are the same, this request is for a distinct and separate encounter. The previous claim processed was for the date of service [Date of First Visit], whereas this claim is for services rendered on [Date of Second Visit].

Please find the following documentation attached to support this appeal:

- CMS-1500 or UB-04 Claim Form for the correct date of service.
- Medical records/Clinical notes for [Date of Second Visit].
- Remittance Advice for the previously paid claim to show the date discrepancy.

We request that you reprocess this claim for payment as a separate and valid date of service. If you require further information, please contact [Contact Person Name] at [Phone Number].

Sincerely,

[Signature]
[Printed Name and Title]