**[Your Name/Organization Name]**
[Address Line 1]
[Address Line 2]
[Phone Number]
[Date]

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

**RE: Appeal for Duplicate Claim Denial**

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

To Whom It May Concern,

This letter is a formal appeal regarding the denial of the above-referenced claim. The claim was denied with the reason code indicating a "Duplicate Claim." However, we are requesting a reconsideration as these represent two distinct admissions occurring on the same calendar day.

The patient was originally discharged on [Date] at [Time]. Due to a significant change in clinical status, the patient required a subsequent and separate readmission on the same day at [Time]. These are not duplicate billings of the same encounter, but two separate clinical episodes of care.

Enclosed you will find the following supporting documentation:

- Discharge summary for the first admission.
- Admission orders and history/physical for the second admission.
- Timed nursing notes confirming the discharge and subsequent return.
- Itemized statements for both distinct encounters.

Please review the attached medical records which verify that the services provided were medically necessary and distinct. We request that the denial be overturned and the claim be processed for payment.

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

Sincerely,

[Your Signature]
[Your Printed Name and Title]