[Provider Name]
[Provider Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

RE: Appeal for Denial of Duplicate Claim
Patient Name: [Patient Name]
Patient Date of Birth: [DOB]
Policy ID Number: [Policy ID]
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 rejected as a duplicate submission. We are requesting a redetermination because the services billed are distinct and separate from the Evaluation and Management (E/M) service provided on the same day.

On [Date of Service], the patient presented for [Reason for Visit]. During this encounter, a significant and separately identifiable E/M service was performed that went beyond the usual preoperative or postoperative care associated with the procedure performed ([CPT Code for Procedure]).

Modifier 25 was correctly applied to the E/M code ([CPT Code for E/M]) to indicate that the patient's condition required a separate evaluation. These are not duplicate services but two distinct components of the patient's care provided during the same visit.

Enclosed you will find the clinical documentation and office notes which support the necessity of both the procedure and the separate E/M service. We request that you reprocess this claim for full payment.

Thank you for your prompt attention to this matter.

Sincerely,

[Signature]
[Printed Name and Title]
[Facility Name]

Enclosures: Copy of original claim, Explanation of Benefits (EOB), Medical Records for [Date of Service].