[Your Name]
[Your Address]
[Your Phone Number]
[Your Email Address]

[Date]

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

RE: Letter of Appeal for Claim #[Claim Number]

Patient Name: [Patient Name]
Policy/Member ID: [ID Number]
Group Number: [Group Number]
Date of Service: [Date of Service]
Provider Name: [Doctor/Facility Name]

To Whom It May Concern:

I am writing to formally appeal the processing of the above-referenced claim. This claim was processed with a patient responsibility of $[Amount], which I believe is incorrect under the Patient Protection and Affordable Care Act (ACA).

The service provided was a preventive [Name of Procedure, e.g., Screening Colonoscopy/Annual Physical/Immunization]. According to federal law, non-grandfathered health plans must cover preventive services recommended by the USPSTF with a Grade A or B, as well as HRSA-supported preventive care, without any cost-sharing (co-payments, co-insurance, or deductibles) when provided by an in-network provider.

I believe this service was billed or processed as diagnostic rather than preventive in error. I have attached [Reference any documents, such as a doctor's note or the original summary of benefits] which confirms this was a routine preventive screening.

Please re-evaluate this claim and adjust the balance to reflect $0.00 patient responsibility. I look forward to receiving a written response regarding the outcome of this appeal within 30 days.

Sincerely,

[Your Signature]

[Your Printed Name]