

[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

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

RE: Letter of Appeal for Denial of Claim

Patient Name: [Patient Full Name]
Policy Number: [Policy/Member ID Number]
Group Number: [Group Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for the following procedure(s): [Procedure Name and CPT Code]. According to the Explanation of Benefits (EOB) dated [Date of EOB], the claim was denied because the procedures were deemed "mutually exclusive."

I am contesting this denial because these procedures were medically necessary and distinct. While these codes are sometimes categorized as mutually exclusive under general billing edits, in this specific clinical instance, they were performed to address separate issues or via separate anatomical sites.

Enclosed, please find the following supporting documentation:

- A letter of medical necessity from my healthcare provider, [Doctor's Name].
- Operative reports and clinical notes detailing the distinct nature of each procedure.
- [List any other relevant medical records or peer-reviewed literature].

Based on the clinical evidence provided, I request that you overturn this denial and process the claim for payment. These services were essential for my treatment and do not represent a duplication of effort or overlapping surgical components.

Please review this appeal and provide a written response within [Number of Days, e.g., 30] days as required by law/policy guidelines. If you require further information, please contact me at [Phone Number].

Sincerely,

[Your Signature]

[Your Printed Name]

Enclosures: [List of attached documents]