

[Date]

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

RE: Formal Appeal for Denied Claim

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

To Whom It May Concern,

This letter serves as a formal appeal regarding the denial of CPT code [Denied CPT Code], which was appended with Modifier -59 (Distinct Procedural Service).

The claim was denied citing that the procedure is bundled or inclusive to [Primary CPT Code]. However, based on the clinical documentation provided, the use of Modifier -59 is appropriate for the following reason:

- [Option 1: The procedure was performed at a different anatomic site or organ system.]
- [Option 2: The procedure was performed through a separate incision or excision.]
- [Option 3: The procedure was performed during a separate session on the same day.]
- [Option 4: The procedure represented a separate lesion or injury.]

Medical records are attached to substantiate that this service was independent and distinct from the other procedures performed during the same encounter. Specifically, [Briefly describe the medical necessity or distinct nature of the procedure].

We request that you re-evaluate this claim and process it for payment. If you require further information, please contact our billing department at [Phone Number].

Sincerely,

[Provider Name or Practice Manager]
[Clinic Name]
[Tax ID/NPI Number]

Enclosures:

- Operative Report/Clinical Notes
- Original Explanation of Benefits (EOB)
- Supporting CMS/CCI Edit Guidelines (if applicable)