

[Physician Name]  
[Practice/Hospital Name]  
[Address]  
[City, State, Zip Code]  
[Phone Number]  
[Date]

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

**RE: Notice of Appeal for Mutually Exclusive Denial**

**Patient Name:** [Patient Name]  
**Date of Birth:** [DOB]  
**Policy ID Number:** [Policy ID]  
**Claim Number:** [Claim Number]  
**Date of Service:** [DOS]

To Whom It May Concern,

I am writing to formally appeal the denial of the following CPT codes: [Denied Code 1] and [Denied Code 2]. These services were denied based on the assertion that they are mutually exclusive. As the attending physician, I am providing clinical justification to demonstrate that these procedures were distinct, medically necessary, and performed independently of one another.

**Clinical Justification:**

[Provide a detailed narrative here. Describe the patient's specific diagnosis and the clinical necessity of performing both procedures. Explain if the procedures were performed at different anatomical sites, through separate incisions, or if one was not a component of the other.]

**Procedure Details:**

- **[CPT Code 1]:** [Brief description of procedure and site]
- **[CPT Code 2]:** [Brief description of procedure and site]

The performance of [CPT Code 1] did not inherently include the work required for [CPT Code 2]. Treating these as mutually exclusive fails to recognize the independent complexity and resources required for each distinct intervention. Attached you will find the operative report and clinical notes supporting the separation of these services.

I request that you overturn this denial and process these claims for full payment. If you require further clinical information, please contact my office directly at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, Title]

[NPI Number]

**Enclosures:** Operative Report, Clinical Progress Notes, Pathology Report (if applicable).