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

[Date]

[Name of Claims Administrator/Insurance Company]
[Appeals Department Address]
[City, State, Zip Code]

RE: Appeal of Denied Claim
Patient Name: [Patient Full Name]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
Policy/Group Number: [Policy Number]

Dear Appeals Committee,

I am writing to formally appeal the denial of the above-referenced claim. The claim was denied on [Date of Denial Notice] for "late submission" or "filing past the timely filing limit."

I am requesting a reconsideration of this claim based on the following circumstances that prevented the timely submission:

[Insert reason here: e.g., delay in receiving necessary medical coding, administrative error by the provider, personal emergency, or incorrect insurance information provided at the time of service.]

Attached to this letter, please find supporting documentation for your review, including:

- [Document 1: e.g., Copy of the original claim]
- [Document 2: e.g., Proof of timely mailing or hospital records]
- [Document 3: e.g., Letter from provider explaining the delay]

Given the medical necessity of the services provided and the circumstances outlined above, I respectfully request that you waive the timely filing requirement and process this claim for payment.

Thank you for your time and for reviewing this appeal. I look forward to your written response within [Number of days, e.g., 30] days.

Sincerely,

[Your Signature]

[Your Printed Name]