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

[Date]

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

RE: Letter of Appeal for Denial of Claim
Patient Name: [Patient Name]
Member ID Number: [Member ID 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 the above-referenced claim. The claim was denied based on Coordination of Benefits (COB) requirements. I believe this denial is in error and wish to provide the necessary information to resolve this matter.

The reason for my appeal is as follows (choose one):

- I do not have any other health insurance coverage. [Insurance Company Name] is my primary and only provider.
- I have updated my COB information with your records department as of [Date].
- [Insurance Company Name] is the secondary payer, and I have attached the Explanation of Benefits (EOB) from my primary insurer, [Primary Insurance Name].

Attached to this letter, please find the following supporting documents:

- A copy of the denial letter/Explanation of Benefits.
- [List other documents, such as a letter of termination from a previous insurer or the EOB from a primary insurer].

Please review this claim again with the updated information provided. I look forward to receiving a written response regarding the outcome of this appeal within [Number of Days, e.g., 30] days.

Thank you for your time and assistance.

Sincerely,

[Your Signature]
[Your Printed Name]