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

[Date]

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

RE: Coordination of Benefits Appeal
Patient Name: [Patient Name]
Member ID: [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 for "Coordination of Benefits" (COB) information requested or because the primary insurer has not processed the claim.

I wish to clarify my insurance coverage as follows:

Primary Insurance: [Name of Primary Insurance Company]
Policy Number: [Policy Number]
Group Number: [Group Number]

Secondary Insurance (if applicable): [Name of Secondary Insurance Company]
Policy Number: [Policy Number]
Group Number: [Group Number]

I have attached the following documentation to support this appeal:

- The Explanation of Benefits (EOB) from my primary insurance carrier showing the amount paid or applied to deductible.
- A completed Coordination of Benefits questionnaire.
- A copy of my current insurance card(s).

Based on this information, please reprocess this claim for payment. If you require further details, please contact me directly at [Your Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]