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

[Date]

[Member Name]
[Member Address]
[City, State, Zip Code]

RE: Notice of Partial Denial of Medical Claim

Member Name: [Member Name]
Member ID: [ID Number]
Claim Number: [Claim Number]
Date of Service: [Date]
Provider: [Provider Name] (Out-of-Network)

Dear [Member Name],

We have processed your claim for services rendered by the out-of-network provider listed above. This letter serves as notification that your claim has been partially denied.

Explanation of Coverage and Payment:

- **Total Amount Billed:** $[Amount]
- **Allowed Amount:** $[Amount]
- **Amount Paid by Plan:** $[Amount]
- **Member Responsibility:** $[Amount]

Reason for Partial Denial:

The provider is not a member of our contracted network. According to your plan benefits, reimbursement for out-of-network services is limited to the Maximum Allowable Charge (MAC) or the Usual, Customary, and Reasonable (UCR) rate. The difference between the provider's billed charge and our allowed amount is not a covered expense.

Balance Billing Notice:

Because this provider is out-of-network, they may "balance bill" you for the difference between the billed amount and the amount paid by this insurance plan. This is in addition to any applicable deductibles or co-insurance.

Right to Appeal:

If you disagree with this decision, you have the right to request a formal review. You must submit your appeal in writing within [Number] days of receiving this notice. Please include the claim number, provider name, and any additional medical documentation or justification for the appeal.

Submit appeals to:
[Appeals Department Address]
[City, State, Zip Code]

If you have questions regarding this letter, please contact Member Services at [Phone Number].

Sincerely,

[Claims Department Representative Name]
[Insurance Company Name]