[Date]

[Policyholder Name]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]

RE: Notice of Partial Denial of Coverage - Claim #[Claim Number]

Dear [Policyholder Name],

We have completed the review of your recent claim submitted on [Date of Claim] for services provided by [Provider Name] on [Date of Service].

After a thorough review of your medical records and policy terms, we must inform you that your claim has been **partially denied**. Below is an explanation of the covered and non-covered portions of your claim:

Status of Benefits:

- **Approved Amount:** $[Amount] (Subject to your deductible and co-insurance)
- **Denied Amount:** $[Amount]

Reason for Partial Denial:
The denied portion of this claim relates to the treatment of [Condition Name]. Based on our review, this is a **pre-existing health condition** as defined in your policy under Section [Section Number].

According to your policy terms, coverage for pre-existing conditions is subject to a waiting period of [Number] months from your effective date of coverage. As your policy began on [Effective Date], the treatment for this specific condition is not eligible for reimbursement at this time.

Next Steps:
The approved portion of your claim has been processed, and payment has been issued to [Provider Name/You]. You are responsible for any remaining balance related to the denied services.

Your Right to Appeal:
If you believe this decision was made in error or if you have additional medical information for us to consider, you have the right to file an appeal. You must submit your written appeal within [Number] days of receiving this letter to the following address:

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

If you have any questions regarding this letter, please contact our Customer Service Department at [Phone Number].

Sincerely,

[Name]
[Title]
[Insurance Company Name]