[Company Name]
[Claims/Appeals Department]
[Address Line 1]
[City, State, Zip Code]

[Date]

[Member Name]
[Address Line 1]
[City, State, Zip Code]

RE: Acknowledgment of Appeal

Member Name: [Member Name]
Member ID: [ID Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
Reference Number: [Appeal Case Number]

Dear [Member Name],

This letter is to confirm that we have received your formal appeal request regarding the denial of the claim mentioned above. We received your request on [Date Received].

Our appeals committee is currently reviewing the information you provided, along with the original claim details and your policy benefits. We may contact your healthcare provider if additional medical records are required to complete this review.

You can expect a written decision regarding your appeal within [30/60] days from the date we received your request. If we require more time or additional information, we will notify you in writing.

If you have any questions or wish to submit further documentation for consideration, please contact our Member Services Department at [Phone Number] or visit our website at [Website].

Sincerely,

[Signature/Name]
[Title]
[Insurance Company Name]