[Date]

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

RE: Appeal Acknowledgment

Member ID: [Member ID Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
Provider Name: [Provider Name]

Dear [Member Name],

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

Our appeals department is currently reviewing your case and all supporting documentation provided. We will evaluate the original processing of your claim to determine if the benefit determination was made according to your health plan guidelines.

Under your plan's requirements, you can expect a written resolution regarding this appeal within [30/60] days of our receipt of your request. If we require additional information from you or your healthcare provider, we will contact you immediately.

If you have any questions or wish to submit additional information for consideration, please contact our Member Services department at [Phone Number] or via our secure portal at [Website].

Sincerely,

[Sender Name/Department]
[Insurance Company Name]