[Date]

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

Re: Appeal Acknowledgment

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

Dear [Patient Name],

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

We are currently reviewing the documentation provided, including any additional clinical notes or X-rays submitted for reconsideration. Our appeals department will conduct a thorough evaluation to ensure your benefits were applied correctly according to your plan coverage.

Under the terms of your policy, a final determination will be made within [Number of Days, e.g., 30] days. You will receive a written notification of the outcome once the review is complete.

If you have any questions in the meantime, please contact our Customer Service Department at [Phone Number] or visit our member portal at [Website Address].

Sincerely,

[Name of Representative/Department]
[Insurance Company Name]