[Date]

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

RE: Final Appeal Determination

Claim Number: [Claim Number]
Date(s) of Service: [Dates]
Provider: [Provider Name]

Dear [Member Name],

We have completed our review of the appeal regarding the claim(s) referenced above. This letter serves as our final determination.

Decision: Partial Overturn

After a thorough review of the additional information provided, we have **partially overturned** our initial decision. This means that a portion of your claim has been approved for payment, while another portion remains denied.

What Was Approved:
The following services/items have been approved for coverage:
[List approved services/amounts]

What Remains Denied:
The following services/items remain denied:
[List denied services/amounts]

Reason for Partial Denial:
The denial for the remaining portion is based on the following reason(s):
[Insert specific plan language, medical necessity criteria, or administrative policy used for the remaining denial]

Payment Information:
The approved portion of the claim will be reprocessed for payment. You will receive an updated Explanation of Benefits (EOB) reflecting the adjusted payment amount within [Number] business days.

Further Rights:
This concludes our internal appeal process. If you disagree with this final determination, you may have the right to request an External Review by an independent third party or pursue legal action under ERISA (if applicable). Instructions for these options are enclosed with this letter.

If you have questions, please contact our Customer Service Department at [Phone Number], [Hours of Operation].

Sincerely,

[Sender Name/Department]
[Company Name]

Enclosure: [List of enclosures/Rights documents]