[Date]

[Recipient Name]
[Recipient Address]
[City, State, Zip Code]

RE: Notice of Final Determination - Appeal Reversed

Claim Number: [Claim Number]
Date of Service: [Date]
Appeal Reference Number: [Reference Number]

Dear [Recipient Name],

We have completed our formal review of your appeal regarding the initial denial of the claim referenced above. Based on a thorough re-evaluation of the additional information provided, we have reached a final determination to **reverse** our original decision.

Reason for Reversal:
The original denial has been overturned because [Insert specific reason, e.g., newly submitted medical records confirm necessity / administrative error was identified]. As a result, the claim is now approved for payment in accordance with the terms of your policy/plan.

Next Steps:

- The claim will be reprocessed for payment immediately.
- You should receive a revised Explanation of Benefits (EOB) or payment within [Number] business days.
- If any portion of the claim remains unpaid due to deductibles or co-insurance, this will be detailed in the upcoming statement.

This decision is final regarding the specific issues raised in this appeal. If you have any questions, please contact our Appeals Department at [Phone Number] or visit our website at [Website URL].

Sincerely,

[Name/Signature]
[Title]
[Organization Name]