

PRACTICE LETTERHEAD — enter your organization name, address, phone, fax, and email below

White-label: replace with your practice branding

[Large empty text box for practice letterhead]

Date:

[Date input field]

To:

Payer Name

[Payer Name input field]

Appeals Department

[Appeals Department input field]

Mailing Address

[Mailing Address input field]

City, State, ZIP

[City, State, ZIP input field]

Re:

FIELD	ENTER YOUR INFORMATION
Date of Letter	[Input field]
Patient Name	[Input field]
Date of Birth	[Input field]
Member / Policy ID	[Input field]
Group Number	[Input field]
Claim Number	[Input field]
Date(s) of Service	[Input field]
Provider Name / NPI	[Input field]
Procedure Code(s)	[Input field]
Denial Code	[Input field]
Amount in Dispute	[Input field]

Dear Appeals Department:

We are writing to formally appeal the denial of the above-referenced claim on the basis that the service has been classified as non-covered. We believe this determination was made in error or without full consideration of the clinical record, and respectfully request a complete review.

**Basis for Appeal:**

- The service billed is a covered benefit under the patient's current plan and was not excluded at the time of service.
- The procedure was medically necessary for the diagnosis and condition documented in the enclosed clinical notes.
- If the service was denied as preventive/routine, the enclosed documentation confirms it was performed for a diagnostic indication — not as a routine screening.
- If the denial is based on an age, gender, or frequency limitation, we have enclosed documentation demonstrating the patient meets coverage criteria or that a medical exception applies.

- If this service is considered non-covered based on a plan exclusion, the patient was not informed of the exclusion prior to service. In that circumstance, we ask that you review any applicable notification obligations before finalizing the denial.
- We request that this claim be reconsidered and reprocessed for payment, or that a detailed written explanation of the specific exclusion clause be provided so the patient may be properly advised of their rights.

**Enclosures / Supporting Documentation:**

- Clinical notes documenting diagnostic (not routine) indication
- Physician order or referral indicating medical necessity
- Relevant ICD-10 diagnosis codes and supporting rationale
- Copy of the patient's Summary of Benefits confirming coverage
- Any prior authorization documentation if obtained
- Patient notification records (or lack thereof) regarding exclusions

**BILLING STAFF TIPS**

- CARC 49 (routine/preventive) denials are frequently overturned when the claim is supported by a diagnostic ICD-10 code — make sure the diagnosis code clearly reflects the clinical indication.
- For CARC 96, 204, or 202 denials, request the specific benefit exclusion language in writing — payers must cite the exact contract provision.
- If the patient was not notified in advance of a potential non-covered service, document this — it may affect whether the patient can be billed.
- Frequency-limit denials (CARC 119, 35) should be appealed with documentation of medical necessity for the additional service.

Sincerely,

\_\_\_\_\_  
Authorized Signature

Name / Title

Practice / Organization

Phone

Fax

Email