

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

White-label: replace with your practice branding

Date:

To:

Payer Name

Appeals Department

Mailing Address

City, State, ZIP

Re:

FIELD	ENTER YOUR INFORMATION
Date of Letter	<div style="border: 1px solid #ccc; height: 15px;"></div>
Patient Name	<div style="border: 1px solid #ccc; height: 15px;"></div>
Date of Birth	<div style="border: 1px solid #ccc; height: 15px;"></div>
Member / Policy ID	<div style="border: 1px solid #ccc; height: 15px;"></div>
Group Number	<div style="border: 1px solid #ccc; height: 15px;"></div>
Claim Number	<div style="border: 1px solid #ccc; height: 15px;"></div>
Date(s) of Service	<div style="border: 1px solid #ccc; height: 15px;"></div>
Provider Name / NPI	<div style="border: 1px solid #ccc; height: 15px;"></div>
Procedure Code(s)	<div style="border: 1px solid #ccc; height: 15px;"></div>
Denial Code	<div style="border: 1px solid #ccc; height: 15px;"></div>
Amount in Dispute	<div style="border: 1px solid #ccc; height: 15px;"></div>

Dear Appeals Department:

We are writing to formally appeal the denial of the above-referenced claim. Our records indicate that the denial was issued based on a benefit maximum, frequency limitation, or plan cap. We respectfully request a full clinical review and reconsideration of this determination.

Basis for Appeal:

- The service in question was medically necessary, and the clinical documentation enclosed demonstrates that the patient's condition required care beyond the standard benefit limitation.
- A benefit maximum should not preclude coverage when the services were rendered for an acute, progressive, or life-threatening condition that warrants continued treatment.
- We are requesting a medical exception or benefit extension on the basis of medical necessity, as documented in the enclosed physician notes and treatment plan.
- If the denial is based on a plan year or lifetime cap, we ask that you confirm whether the patient has exercised their right to external review under applicable state and federal law.

- Under the Mental Health Parity and Addiction Equity Act (MHPAEA), where applicable, benefit limitations applied to behavioral health services must be no more restrictive than those applied to medical/surgical services. If this denial involves behavioral health, we ask that parity compliance be confirmed.
- We respectfully request that this claim be approved, or that a peer-to-peer review be scheduled so our clinical team can speak directly with your medical reviewer.

Enclosures / Supporting Documentation:

- Complete clinical notes supporting continued/additional service
- Physician letter of medical necessity
- Treatment plan showing clinical rationale for exceeding limitation
- Evidence-based clinical guidelines supporting the service frequency
- Prior claims history showing benefit utilization (if relevant)
- Any applicable parity analysis for behavioral health services

BILLING STAFF TIPS

- Benefit maximum denials are most successfully appealed when paired with a strong physician letter of medical necessity that references the specific clinical criteria justifying the additional service.
- For CARC 35 (lifetime maximum) or CARC 119 (frequency limit), always request the exact provision in writing — benefit limits must be disclosed.
- CARC 233 (hospital-acquired condition) appeals require a review of the POA (Present on Admission) indicator — if it was incorrectly coded, the denial may be reversed.
- For CARC 60 (72-hour bundling rule), review whether the outpatient services are specifically exempt from bundling under CMS guidelines.

Sincerely,

Authorized Signature

Name / Title

Practice / Organization

Phone

Fax

Email