

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: 20px;"></div>
Patient Name	<div style="border: 1px solid #ccc; height: 20px;"></div>
Date of Birth	<div style="border: 1px solid #ccc; height: 20px;"></div>
Member / Policy ID	<div style="border: 1px solid #ccc; height: 20px;"></div>
Group Number	<div style="border: 1px solid #ccc; height: 20px;"></div>
Claim Number	<div style="border: 1px solid #ccc; height: 20px;"></div>
Date(s) of Service	<div style="border: 1px solid #ccc; height: 20px;"></div>
Provider Name / NPI	<div style="border: 1px solid #ccc; height: 20px;"></div>
Procedure Code(s)	<div style="border: 1px solid #ccc; height: 20px;"></div>
Denial Code	<div style="border: 1px solid #ccc; height: 20px;"></div>
Amount in Dispute	<div style="border: 1px solid #ccc; height: 20px;"></div>

Dear Appeals Department:

We are writing to formally appeal the denial of the above-referenced claim, which was issued due to a reported coding or billing error. After thorough review of the original claim and supporting clinical documentation, we have identified the issue and submit the following corrected information for your consideration.

Basis for Appeal:

- A review of the claim confirms the specific coding correction described below. A corrected claim is enclosed.
- The procedure code submitted is consistent with the service rendered, the provider's documentation, and applicable CPT coding guidelines in effect on the date of service.
- The modifier appended to the procedure code accurately reflects the clinical circumstances of the service. Supporting documentation (operative notes, physician attestation) is enclosed.

- Any diagnosis-to-procedure, age, or gender inconsistency identified in the original claim has been reviewed and corrected. The corrected codes are supported by the clinical record.
- The applicable CPT Assistant guidelines and CMS coding instructions support the codes as submitted (or as corrected herein). Specific references to the applicable guidance are provided in the enclosed documentation.
- We respectfully request that the corrected claim be processed and that payment be remitted in accordance with your contracted fee schedule. If additional information is required, please contact our billing department directly.

Enclosures / Supporting Documentation:

- Corrected CMS-1500 or UB-04 claim form
- Operative report or clinical notes supporting the procedure code
- Physician attestation of service rendered (if E/M level disputed)
- CPT Assistant guideline reference or AMA coding guidance
- Modifier documentation (separate service justification, distinct procedure evidence)
- Diagnosis-to-procedure crosswalk or LCD/NCD reference (if applicable)
- Original EOB / denial explanation

BILLING STAFF TIPS

- For modifier denials (CARC 4), always include the specific CPT Assistant or AMA guidance that supports the modifier — and attach operative notes if it's a surgical modifier.
- CARC 16 (missing/invalid information) denials often come with a companion RARC code that identifies the specific field — pull the RARC before writing the appeal so you address the right issue.
- For place-of-service denials (CARC 5), verify whether the service should have been billed as facility or non-facility and whether the provider was enrolled for both settings.
- New patient code denials (CARC B16) can be appealed if the patient had not been seen in 3+ years — document the last encounter date.
- Unlisted code (CARC 189) denials require a detailed narrative description of the service in addition to the appeal — submit this as a separate typed attachment.

Sincerely,

Authorized Signature

Name / Title

Practice / Organization

Phone

Fax

Email