

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. The denial indicates that a plan-required procedure, authorization, or guideline was not followed. We respectfully submit the following information in support of our appeal and request full reconsideration.

Basis for Appeal:

- The service in question was rendered under emergent or urgent circumstances that did not permit compliance with the plan's standard pre-authorization or notification requirement. Clinical documentation of the emergent nature is enclosed.
- If the denial is based on failure to obtain a second surgical opinion, we provide documentation confirming the clinical urgency that precluded this step, or confirming the second opinion was in fact obtained.
- For managed care or capitation-based denials, we are requesting clarification of whether the specific service is included in the capitation arrangement or is a carve-out benefit separately billable.

- Where a plan procedural requirement was not met, we respectfully request that the payer consider whether the patient would have been harmed by the delay required to comply with the procedure, and whether a retroactive exception is warranted.
- We note that plan provisions may not be applied in a manner that results in unjust denial of medically necessary care. Under applicable state law / ERISA / ACA, plan participants have the right to receive a full and fair review of any claim denial.
- We request either approval of this claim or a written statement identifying the specific plan provision cited, the date it was communicated to the provider, and the procedure for obtaining a retroactive exception.

Enclosures / Supporting Documentation:

- Clinical documentation supporting medical necessity and urgency
- Emergency department records or admitting physician notes (if applicable)
- Second surgical opinion documentation (if applicable)
- Managed care contract or benefit summary identifying carve-out provisions
- Plan notification or enrollment materials showing provider was informed of requirements
- Prior authorization attempts (timestamps, reference numbers)

BILLING STAFF TIPS

- CARC 95 (plan procedures not followed) is one of the most successfully appealed denial codes when paired with documentation of emergency circumstances — if the patient needed immediate care, say so explicitly.
- For CARC 256 (managed care contract), request a copy of the specific contract carve-out language — payers sometimes misapply capitation terms to services that are actually billable separately.
- CARC 61 (second surgical opinion) denials can often be resolved by demonstrating that the plan requirement was not communicated to the provider or patient in writing prior to the procedure.
- CARC 278 (performance program) denials should be appealed if the metrics cited are disputed — request the specific calculation methodology and data used to determine non-compliance.
- Always document the exact date you became aware of the plan requirement and how it was communicated to your practice.

Sincerely,

Authorized Signature

Name / Title

Practice / Organization

Phone

Fax

Email