

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

Dear Appeals Department:

We are writing to formally appeal the denial of the above-referenced claim. The denial indicates a coordination of benefits (COB) issue, including that another payer may be liable for this claim. After reviewing the patient's coverage at the time of service, we submit the following findings and request reconsideration.

**Basis for Appeal:**

- We have confirmed with the patient that this claim is directed to the correct primary payer for the date(s) of service listed above. Supporting documentation of primary coverage is enclosed.
- If the denial is based on a Workers' Compensation or liability carrier being primary, we enclose documentation from the patient confirming this injury was not work-related / not the result of a covered accident.
- If the denial was issued because the claim was sent to the wrong payer, we are resubmitting to the correct payer and providing this appeal for your records.

- If this claim was denied because primary payer information is on file from a prior period and has since changed, we provide updated COB verification confirming current primary/secondary status.
- We have conducted a real-time eligibility verification confirming this plan's liability for the claim. The 270/271 eligibility response, showing this plan as primary, is enclosed as a supporting exhibit.
- We respectfully request that this claim be reprocessed with the correct payer order applied, or that we be provided with specific documentation of the coordination of benefits determination that resulted in this denial.

**Enclosures / Supporting Documentation:**

- Current insurance card(s) for the patient
- 270/271 eligibility verification confirming payer priority
- Patient statement confirming primary/secondary coverage
- Medicare Secondary Payer (MSP) questionnaire (if Medicare involved)
- Workers' Compensation non-involvement statement (CARC 19–21)
- Primary payer EOB (if this is a secondary payer appeal)
- Corrected claim with updated COB information (if applicable)
- Documentation of prior COB determination (if disputing prior ruling)

**BILLING STAFF TIPS**

- COB denials (CARC 22) are most cleanly resolved by submitting the primary payer's EOB along with the secondary claim — always attach the EOB when billing secondary.
- For CARC 19 (Workers' Comp) or CARC 20 (liability carrier) denials, a signed patient statement is often sufficient to redirect the claim — get it quickly before the timely filing window closes.
- CARC 109 (wrong payer) denials require you to identify the correct payer and refile — check that the payer ID used at submission matched the patient's current insurance card.
- Medicare Secondary Payer rules are complex — if Medicare denied as secondary, confirm the MSP questionnaire was completed at admission or registration.
- When COB is disputed, document every call with the patient and both carriers with date, time, and representative name — this creates an audit trail if the dispute escalates.

Sincerely,

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

Name / Title

Practice / Organization

Phone

Fax

Email