[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Claims Department]
[Insurance Company Address]
[City, State, Zip Code]
Subject: Dispute of Claim [Claim Number]
Dear Claims Department,
I am writing to formally dispute the denial of my medical insurance claim related to [brief description of the medical service or treatment] under claim number [Claim Number] submitted on [Date of Claim Submission].
Details of the Claim:
- Patient Name: [Your Full Name]
- Policy Number: [Your Policy Number]
- Service Date: [Date of Service]
- Provider Name: [Name of Healthcare Provider]
In your letter dated [Date of Denial Letter], it was stated that my claim was denied due to [reason provided by the insurance company]. I believe this decision to be incorrect because [provide a detailed explanation supporting your claim, including any relevant medical records, communications with your provider, or policy provisions].
To assist in the review of my case, I have enclosed the following documents:
1. A copy of the denial letter
2. Relevant medical records and bills
3. Any additional supporting documentation (e.g., letters from the healthcare provider)
I kindly request that you review my claim and reconsider your decision. Please confirm receipt of this letter and let me know if you require any further information.
Thank you for your attention to this matter. I look forward to your prompt response.
Sincerely,
[Your Name]
[Your Signature (if sending a hard copy)]