

[Your Name]
[Your Title]
[Your Organization]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]

[Insurance Company Name]
[Claims Department]
[Insurance Company Address]
[City, State, Zip Code]

Subject: Request for Review of Medical Claim [Claim Number]

Dear [Claims Adjuster's Name],

I hope this letter finds you well. I am writing to formally contest the denial of medical claim number [Claim Number], dated [Date of Service], for [Patient's Name].

[Briefly explain the reason for the claim, including diagnosis, treatment provided, and any relevant medical history.]

According to [provide specific references to policy provisions, medical codes, or guidelines], I believe that this claim meets the necessary criteria for approval. Enclosed, please find the following documents for your review:

1. Itemized bill for services rendered
2. Medical records supporting the treatment
3. Any additional documentation (as necessary).

I kindly request a thorough review of this claim. I appreciate your attention to this matter and look forward to your prompt response.

Thank you for your cooperation.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Position/Title]
[Your Organization]