[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company's Name]
[Claims Department Address]
[City, State, Zip Code]
Re: Appeal of Claim Denial - [Claim Number]
Dear [Claims Manager's Name],
I am writing to formally appeal the denial of my medical claim, #[Claim Number], which was submitted on [Date of Service]. The claim was denied on [Date of Denial] for the reason stated in your letter dated [Date of Denial Letter].
I believe this claim is valid and should be reconsidered due to the following reasons:
1. **[First Reason for Appeal]**: [Provide a detailed explanation and any supporting documentation].
2. **[Second Reason for Appeal]**: [Provide a detailed explanation and any supporting documentation].
3. **[Additional Reasons if Necessary]**: [Provide any additional relevant details or evidence].
I have included copies of [list any attached documents, e.g., medical records, bills, previous correspondence] to support my appeal.
In light of this information, I respectfully request a thorough review of my claim and look forward to your prompt response. Please feel free to contact me at [Your Phone Number] or [Your Email Address] if you need any additional information.
Thank you for your attention to this matter.
Sincerely,
[Your Signature (if sending a hard copy)]
[Your Printed Name]