[Your Name]
[Your Address]
[City, State, ZIP Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Claims Department Address]
[City, State, ZIP Code]
Subject: Complaint Regarding Denial of Medical Claim [Claim Number]
Dear [Insurance Company Representative's Name],
I am writing to formally contest the denial of my recent medical claim, numbered [Claim Number], submitted on [Date of Claim Submission].
Details of the Claim:
- **Patient Name:** [Your Name]
- **Policy Number:** [Your Policy Number]
- **Date of Service:** [Date of Service]
- **Provider Name:** [Healthcare Provider Name]
I was notified of the denial on [Date of Denial Notification], citing [Reason for Denial]. After reviewing my policy and the details of the services rendered, I believe that this claim should be covered [briefly explain your reasoning or any relevant policy specifics].
I have attached supporting documents, including [list attached documents, e.g., medical records, bills, correspondence], to assist in the review of this matter.
I kindly request a re-evaluation of my claim and a written response within [number of days, e.g., 30 days]. If needed, I am open to discussing this matter further and providing any additional information required.
Thank you for your attention to this matter.
Sincerely,
[Your Name]