

[~Current Date~]

Attn: Director of Claims

[~Insurance Policy #1 Carrier~]

[~Insurance Policy #1 Address~]

Re: Patient: [~Patient Name~]
Policy: [~Insurance Policy #1 Number~]
Insured: [~Responsible Party Name~]
Treatment Dates: [~Admission Date~] - [~Discharge Date~]
Amount: [~Total Charges~]

Dear Director of Claims,

The above referenced claim was denied despite the fact that verification of benefits and/or preauthorization of care was obtained from your company. Please be advised, our facility relies on information received from your company regarding coverage. We extended treatment in good faith based on the expectation of payment as quoted by your company.

Many state courts have held that insurers can be liable for misrepresentations made during coverage verification and utilization review. Such rulings often rely on the legal theory of equitable estoppel wherein a party who makes a misstatement of fact is estopped from denying another party the right of benefits when that party relied on incorrect information to his or her detriment.

Further, most states have an Unfair Claims Settlement Practices Act prohibiting licensed insurance companies from knowingly misrepresenting material fact or relevant policy provisions in connection with a claim. It is our position that your duty as the insurer is to provide accurate information at the time of verification of benefits/utilization review.

Based on this information, we request immediate payment of the above referenced claim in accordance with the benefits quoted at the time of the patient's admission. We request a response to this appeal within 14 days of your receipt.

Sincerely,

Claims Analyst