[~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,

According to the explanation of benefits, your company appears to have reduced payment as a result of downcoding, fee schedule application or other contractual adjustment. Please accept this letter as a formal appeal of this benefit reduction.

N.J. Administrative Code, Title 8 r. 38A-2.3, "Disclosure requirements," stipulates that any reductions or limitations to benefits must be clearly and unambiguously disclosed in the insurance benefit documents. Specifically, carriers must clearly distinguish the covered person's financial responsibility for deductibles, copays and usual and customary denials as described below:

> (a) Carriers shall provide to each subscriber within no more than 30 days following the effective date of coverage, and upon request thereafter, through a handbook, certificate or other evidence of coverage designed for covered persons, information describing the following:
> 1. The services or benefits therefor to which a covered person is entitled under the policy or contract, including: i. All exclusions and limitations with respect to at least physical and occupational therapy, clinical laboratory tests, hospital and surgical procedures, prescription drugs and biologics, radiological examinations and behavioral health services; ii. All restrictions on accessing covered services, such as the requirement to obtain prior authorization, preadmission certification, or periodic review of on-going treatment; iii. A full and clear description of the carrier's policies and procedures governing the provision of emergency and urgent care services or the payment of benefits therefor, including a statement that emergency or urgent care services are not covered, if that is the case; and iv. All dollar, day, visit or procedure limitations applicable to at least those services set forth at (a)1i above, and the method for exchanging inpatient for outpatient services or vice versa, when such exchanges are permitted under the policy or contract;
> 2. The responsibility of the covered person to pay deductibles, coinsurance or copayments, as appropriate. i. Carriers shall clearly distinguish any differences in the covered person's financial responsibility for accessing services within and outside of a carrier's network, when applicable; ii. Carriers shall explain the covered person's responsibility to pay for charges incurred that are not covered under the policy or contract. iii. Carriers shall explain the covered person's responsibility to pay for charges that exceed what the carrier determines are customary and reasonable charges (usual and customary, or usual, customary and reasonable, as appropriate to the carrier) for services that are covered under the policy or contract in those instances in which service is rendered by an out-of-network provider;

It is our position that the above referenced claim was correctly coded and that additional benefits are due. If benefits remain denied, please provide a detailed explanation of how the reimbursement was determined and where in the

contract such exceptions, reductions and limitations were explained. If additional information is required from this office, please submit a written request.

Sincerely,

Claims Analyst