

[~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,

Our office recently filed an appeal related to the above referenced claim. However, no response was received from your company. It is our position that this failure to promptly respond to the issues outlined in our appeal letter is a violation of New Jersey law. Therefore, we request immediate approval of the claim.

As you are likely aware, certain health maintenance organizations must respond to a formal appeal within the time frames established by N.J. Administrative Code, Title 8 r. 38-3.6. Under this regulation, health maintenance organizations must respond to an appeal within 30 days from receipt of the appeal.

Because your failure to promptly respond may affect your liability regarding this claim, we request that benefits be immediately allowed. If benefits are not approved, we ask that an appeal response be immediately faxed or sent overnight to this office. Any decision to deny care should include the name and credentials of the reviewer who reached the decision so that we may verify that he or she has sufficient training to reach the denial decision.

Sincerely,

Claims Analyst