[~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 the American Accreditation Commission's URAC Health Utilization Management Standards.

As you are likely aware, URAC standards require that all accredited members conduct appeal consideration in accordance with the following timeframes:

> The organization observes the following timeframes for appeal:
> (a) Expedited appeals are completed (i.e., written notification of the appeal decision issued) as soon as possible, and no later than 72 hours after the initiation of the appeal process;
> (b) Standard appeals are completed (i.e., written notification of the appeal decision issued) within 30 calendar days of the initiation of the appeal process (**Standard UM 41**)
> Written notification of adverse appeals determinations includes:
> (a) The principal reasons for the determination to uphold the non-certification;
> (b) A statement that the clinical rationale used in making the appeal decision will be provided, in writing, upon request; and
> (c) In the case of expedited appeals, the method to initiate the standard appeal process.

Please accept this written request for a written appeal response which includes the clinical rationale used in making the decision. Also, please provide the name and credentials of the reviewing physical therapist who was available at the time of this decision for peer-to-peer discussion of this case. Thank you for your immediate assistance in this matter.

Sincerely,

Claims Analyst