

[~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,

We are in receipt of the benefit payment for the above referenced claim.

It is our understanding that benefits were significantly reduced due to your determination that the billed charges are more than the usual and customary rate for certain procedures or items.

We do not believe the reduction is justified. As you are likely aware, such provider reimbursement rates are typically adjusted based on the usual and customary treatment charges for that specialty and the geographical region where treatment was provided. Further, many state and federal disclosure laws require insurers and administrators to advise beneficiaries and providers as to how the reimbursement rate is determined. However, the payment rendered does not appear to be comparable to rates charged for this service locally and no information has been given to support your position that the denial is correct.

Based on this information, we request that the reductions be reversed and an additional payment be made. If your company does not release additional benefits, please submit the applicable policy language which justified the reduction as well as the data used to establish the reimbursement rate so that we may determine your company's and the patient's liability in regards to the unpaid balance.

We appreciate your prompt attention to this matter.

Sincerely,

Claims Analyst

[Current Date]

Attn: Director of Claims
[Insurance Policy Carrier]
[Insurance Policy Address]

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

Dear Director of Claims,

It is our understanding that this claim was denied pursuant to your decision that the care was not medically necessary.

The explanation of benefits did not give adequate information to establish the accuracy of this decision. Therefore, please provide the following information to support the denial of benefits for this treatment.

Please furnish the name and credentials of the insurance representative who reviewed the treatment records. Also, please provide an outline of the specific records reviewed and a description of any records which would be necessary in order to approve the treatment.

Further, we would appreciate copies of any expert medical opinions which have been secured by your company in regards to treatment of this nature and its efficacy so that the treating therapist may respond to its applicability to this patient's condition.

Thank you for your assistance.

Sincerely,

Patient Accounts Manager