SAMPLE PAYER APPEAL LETTER

[DATE]

Appeals Department
[PAYER NAME]
[PAYER ADDRESS]

Dear Appeals Department staff,

[AGENCY NAME] appreciates the ease and effectiveness of our interactions with [PAYER NAME]. In general, EOBs are easy to read, payment it timely, and customer service staff are quick to respond. However, [AGENCY NAME] has identified a persistent error that we wish to bring to your attention.

As mandated by the Affordable Care Act (ACA), [APPLICABLE SERVICE] following the US Preventive Services Task Force guidelines is a preventive service that must be covered by all applicable plans. Despite this requirement, [PAYER NAME] has consistently denied [AGENCY NAME]'s claims submitted for this service.

[AGENCY NAME] submitted claims to [PAYER NAME] for [APPLICABLE SERVICE] using [CPT/HCPCS CODE] AND [ICD-9 OR ICD-10 CODE].

PT NAME	PT DOB	MEMBER ID	CLAIM #	DATE OF SERVICE	CLAIM TOTAL	ITEM IN APPEAL

I trust you will determine that these claims are valid and previous non-payment was made in error by [PAYER NAME]. Please forward this information to your medical review staff to prevent this error from becoming an ongoing problem.

Thank you for your prompt attention to this matter. Please contact [AGENCY REPRESENTATIVE] at [CONTACT INFORMATION] in our office should you have any questions regarding this claim.

Sincerely,

[AGENCY REPRESENTATIVE]

National Family Planning & Reproductive Health Association