Claim Appeal Letter

Date: [Insert Date]

[Your Name]
[Your Address]
[City, State, Zip]
[Your Email]
[Your Phone Number]

[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip]

Dear [Claims Manager's Name],

I am writing to formally appeal the denial of my claim for medical expenses related to [brief description of the medical condition or treatment] under claim number [insert claim number]. I received a notice of denial dated [insert date of the denial notice], stating the claim was denied due to [specific reason for denial].

I believe this decision may have been made in error as [explain your reasoning or additional supporting information]. I have attached relevant documents, including [list any attached documents, such as medical records, bills, or previous correspondence].

I kindly request a thorough review of my case and the consideration of my appeal. I believe that my medical expenses are valid and fall within my policy's coverage. Your prompt attention to this matter would be greatly appreciated.

Thank you for your consideration.

Sincerely,

[Your Name]