Claims Department

Date: [Insert Date]

Recipient Name: [Insert Recipient Name]

Address: [Insert Recipient Address]

City, State, Zip: [Insert City, State, Zip]

Subject: Coverage Denial Explanation for Pre-Existing Conditions

Dear [Recipient Name],

We are writing to inform you about the decision regarding your recent claim for medical coverage, submitted on [Insert Claim Date]. After a thorough review, we regret to inform you that your claim has been denied based on the policy stipulations regarding pre-existing conditions.

Our review of your medical history indicated that the condition related to your claim [Insert Condition] was present prior to the effective date of your coverage. As stated in your policy under section [Insert Policy Section], any treatment or services related to pre-existing conditions are not covered for a specified time frame.

We recommend reviewing your policy document for further clarification on the terms related to pre-existing conditions, as it provides detailed information about coverage limitations and exclusions.

If you believe that this decision is incorrect, you may appeal it by submitting additional documentation or information that supports your case within [Insert Time Frame for Appeal]. Please send your appeal to [Insert Appeal Address or Email].

Thank you for your understanding. Should you have any questions regarding this decision, please do not hesitate to contact our customer service team at [Insert Contact Number].

Sincerely,

[Your Name]

[Your Title]

Claims Department