Policyholder Coverage Denial Explanation

Date: [Insert Date]

Policyholder Name: [Insert Policyholder's Name]

Policy Number: [Insert Policy Number]

Dear [Policyholder's Name],

We are writing to inform you about a recent decision regarding your claim for services provided by an out-of-network provider on [Insert Date of Service]. After a thorough review, we regret to inform you that your claim has been denied due to the following reason:

Reason for Denial: Your policy stipulates that services from out-of-network providers are not covered unless pre-authorization was obtained prior to receiving treatment. In this instance, our records indicate that no such authorization was granted.

Please note that while we strive to provide our policyholders with comprehensive coverage, certain limitations apply. We encourage you to refer to your policy documentation for additional details regarding your benefits.

If you believe this decision was made in error, you have the right to appeal. Please submit any additional information that may support your case to our claims department at [Insert Claims Department Contact Information].

Thank you for your understanding.

Sincerely,

[Your Name]

[Your Title]

[Insurance Company Name]

[Contact Information]