Medical Bill Dispute Appeal

Date: [Insert Date]

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

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

Dear [Insurance Company Representative's Name],

Subject: Appeal of Denied Claim - [Claim Number]

I am writing to formally appeal the denial of my claim dated [date of service] related to [brief description of the service]. My insurance claim was denied on [date of denial], and the reason provided was [insert reason for denial].

I believe this claim should be reconsidered based on the following reasons:

1. [Reason 1]
2. [Reason 2]
3. [Reason 3]

Attached are copies of relevant documents including [list any attached documents such as bills, medical records, or previous correspondence].

Please review this information and reconsider the claim denial. I appreciate your attention to this matter and look forward to your prompt response.

Thank you for your assistance.

Sincerely,

[Your Name]