Letter of Contested Health Claim Decision

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

[Date]

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

Re: Contesting Health Claim Decision - Claim #[Claim Number]

Dear [Claims Adjuster or Insurance Representative's Name],

I am writing to formally contest the decision regarding my health claim #[Claim Number] dated [Date of Communication]. I was notified on [Date] that my claim was denied due to [Reason for Denial]. I believe this decision warrants reconsideration based on the following information:

[Briefly explain the reasons why you believe the claim should be approved, including any relevant medical information, treatment details, or additional documentation you plan to provide.]

Attached are copies of [list any supporting documents such as medical records, bills, or correspondence] that support my position. I request that my claim be reviewed with this additional information in mind.

I appreciate your prompt attention to this matter. Please contact me at [Your Phone Number] or [Your Email Address] if further information is needed. I look forward to your timely response.

Thank you for your understanding.

Sincerely,

[Your Name]