Medical Insurance Complaint Regarding Denied Claims

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

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

Dear Claims Department,

I am writing to formally dispute the denial of my recent medical claim (Claim Number: [Claim Number]) dated [Claim Date]. I believe this claim was denied in error, and I would like to request a thorough review of the circumstances surrounding this matter.

On [Date of Service], I received medical treatment for [Brief Description of Treatment]. My healthcare provider, [Provider Name], submitted the necessary documentation for my claim; however, it was denied on [Denial Date] for the reason stated as [Reason for Denial].

I have attached copies of all relevant documents including:

- Medical bills
- Provider's notes
- Any correspondence from your office

According to my policy [Policy Number], the claimed services should be covered. I kindly request that you reassess my claim and provide a detailed explanation if further documentation is required.

Thank you for your prompt attention to this matter. I look forward to your response within [Specify Time Frame, e.g., 30 days].

Sincerely,
[Your Name]