# Benefit Denial Explanation

Date: [Insert Date]

Claim Number: [Insert Claim Number]

Insured Name: [Insert Insured Name]

Address: [Insert Address]

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

Dear [Insert Insured Name],

We regret to inform you that your claim for insurance benefits associated with [specific service or treatment] has been denied.

The reason for this denial is as follows:

- [Reason 1: e.g., services not covered under your policy]
- [Reason 2: e.g., lack of pre-authorization]
- [Additional reasons if applicable]

If you believe that this decision is incorrect, you have the right to appeal. Please provide any additional information or documentation that you believe supports your claim.

For more details on the appeals process, please refer to your policy or contact our customer service at [Insert Phone Number].

Thank you for your understanding.

Sincerely,

[Your Name]

[Your Title]

[Insurance Company Name]

[Insurance Company Contact Information]