

Appeal for Rejected Claim

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, ZIP Code]

[Email Address]

[Phone Number]

[Claims Department Name]

[Insurance Company Name]

[Company Address]

[City, State, ZIP Code]

Dear [Claims Department Name],

I am writing to formally appeal the decision regarding my claim [Claim Number], which was rejected on [Date of Rejection].

Upon reviewing the details and the reasons provided for the rejection, I believe there may have been misunderstandings or overlooked information that warrant a reassessment of my claim.

Attached to this letter are the relevant documents supporting my claim, including [list any attached documents, e.g., medical records, receipts]. I kindly request that you review the information and reconsider your decision.

Thank you for your attention to this matter. I look forward to your prompt response.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]