Out-of-Network Expense Appeal

Date: [Insert Date]

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

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

Dear [Insurance Company Contact/Department],

I am writing to formally appeal the out-of-network expense associated with my recent medical treatment on [Date of Service]. My policy number is [Your Policy Number] and the claim number is [Claim Number].

Despite my understanding that the provider was out-of-network, I believed that the services were necessary due to [brief explanation of the medical circumstances]. I would like to request a reevaluation of the claim, as the provider was essential for my care and there were limited in-network options available.

Please find attached documents supporting my appeal, including [list of documents, e.g., medical records, bills, letters from the provider].

I appreciate your attention to this matter and look forward to your prompt response. Thank you for considering my appeal.

Sincerely,
[Your Name]