

FACES:

The National Craniofacial Association 1-800-332-2373

SAMPLE LETTER TO USE WHEN INSURANCE COMPANY DENIES CLAIM

(FILL IN THE BLANKS AND SEND WHEN YOUR INSURANCE COMPANY WILL NOT PAY ON A CLAIM)

(Your Name)
(Your Address)
(Your City, State, and Zip)
(Date)

(Your Insurance Company)

ATTENTION: Claims Review Committee
RE: Claim Number 000000

You recently denied payment on this claim. I am preparing my records to appeal this denial and wish you to provide the following information in writing as soon as possible:

- 1) The reason, in detail, this claim was denied;
- 2) The section number and paragraph referenced in my policy which provide the reason for this denial;
- 3) The name of the party who reviewed and denied this claim;
- 4) All conditions which must be met which would entitle this claim to be covered.

Please provide in your response, the name address, and phone number of the person responding, along with the name of his or her supervisor.

Sincerely,

(Your Name)

cc: (Name of your insurance Plan Administrator)