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Prior Authorization Denial Appeal

Appeal a service denied due to missing or invalid prior authorization

PROVIDER INFORMATION

Date:	*[Today's Date]*
Practice Name:	*[Your Practice Name]*
Address:	*[Street, City, State, ZIP]*
Phone:	*[Phone Number]*
NPI:	*[NPI Number]*
Tax ID:	*[Tax ID / EIN]*

PAYER / INSURANCE COMPANY

Insurance Company:	*[Insurance Company Name]*
Appeals Department:	*[Department Name or Address]*
Address:	*[Street, City, State, ZIP]*
Fax:	*[Fax Number]*

CLAIM REFERENCE

RE: APPEAL OF CLAIM DENIAL

Patient Name: *[Patient Full Name]*
Date of Birth: *[MM/DD/YYYY]*
Member / Policy ID: *[Member ID]*
Claim Number: *[Claim Number]*
Date of Service: *[MM/DD/YYYY]*
CPT Code(s): *[CPT Code(s)]*
Auth Number (if obtained): *[Authorization Number or N/A]*
Denial Reason: CO-15 / CO-167 — Prior Authorization

LETTER OF APPEAL

Dear [Insurance Company] Appeals Department,

We are appealing the denial of the above-referenced claim on the basis that [SELECT ONE ARGUMENT BELOW]:

ARGUMENT 1 — Authorization was obtained: Prior authorization was obtained for this service. Authorization number [auth number] was issued on [date] and was valid for the date of service. A copy of the authorization confirmation is enclosed. We request that the claim be reprocessed accordingly.

ARGUMENT 2 — Authorization was not required: This service does not require prior authorization under [patient's] benefit plan for [CPT code / service description]. Per [payer] policy [cite policy or EOB language if available], [service type] is exempt from prior authorization requirements when [describe circumstance — e.g., rendered by an in-

network provider, under a certain dollar threshold, for a covered preventive service]. Supporting documentation is enclosed.

ARGUMENT 3 — Retroactive authorization / emergent service: This service was rendered on an emergent / urgent basis, making it impossible to obtain prior authorization in advance. Per [payer] policy and applicable state law, services rendered in an emergent situation should be approved retroactively when medically necessary. Clinical documentation supporting the urgent nature of the service is enclosed.

ARGUMENT 4 — Payer error / authorization not linked to claim: Authorization [auth number] was on file at the time of service but was not applied to this claim. This appears to be a payer system error. We request that the claim be reprocessed with the authorization linked and reimbursed accordingly.

We request reversal of this denial and processing of the claim for the authorized services. Please contact our office at [phone number] if additional information is needed.

ENCLOSURES

- Copy of authorization approval (if obtained)
- Payer communication confirming authorization (phone log / portal screenshot)
- Clinical documentation supporting emergent nature (if applicable)
- Excerpt from payer policy exempting this service from prior auth (if applicable)

Sincerely,

Provider Signature: ______________________________

Printed Name: *[Provider Name]*

Title: *[Title / Credentials]*

Date: *[Date]*

Enclosures listed above. Keep a copy of this letter and all supporting documentation for your records.

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