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Coordination of Benefits Appeal Letter

Appeal a denial or reduced payment related to primary / secondary payer coordination

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]*
Primary Payer: *[Primary Insurance Name / ID]*
Secondary Payer: *[Secondary Insurance Name / ID]*
Claim Number: *[Claim Number]*
Date of Service: *[MM/DD/YYYY]*
Denial / Reduction Code: CO-22 / CO-23 — COB

LETTER OF APPEAL

Dear [Insurance Company] Appeals Department,

We are appealing the denial / payment reduction on the above-referenced claim related to coordination of benefits (COB). The claim was denied or reduced with reason code CO-22 / CO-23. We respectfully request reconsideration based on the following:

PRIMARY / SECONDARY DETERMINATION: [Describe the correct COB order. Example: The patient's primary coverage is through [Primary Payer] (Group: [Group No.], Member ID: [ID]). [Insurance Company being appealed] is the secondary payer. Primary payment was received in the amount of $[amount] on [date]. The remaining patient liability per the primary EOB is $[amount], which should be considered for secondary benefit payment.]

[SELECT ADDITIONAL ARGUMENT IF APPLICABLE]

ARGUMENT — Incorrect COB order applied: The payer has incorrectly identified [Insurance Company] as the primary payer. Under the [Birthday Rule / COBRA order / employer plan coordination rules / other applicable rule], [Primary Payer] is the correct primary payer for this patient. Documentation supporting the correct COB order is enclosed.

ARGUMENT — Non-duplication vs. maintenance of benefits: The secondary plan applies a [non-duplication / maintenance of benefits] provision. However, because the primary payer paid less than the secondary plan would have paid as primary, a secondary benefit is still payable. Calculation details are enclosed.

We request that [Insurance Company] reconsider this claim using the correct COB order and apply available secondary benefits. Primary EOB and supporting COB documentation are enclosed.

ENCLOSURES

- Primary payer EOB showing payment and patient liability
- Copy of primary claim (CMS-1500 / 837P)
- Documentation establishing correct COB order (if disputed)
- Secondary claim with primary EOB attached

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.