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Out-of-Network Appeal Letter

Appeal a denial or reduced payment due to out-of-network provider status

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)]*
Provider NPI: *[NPI Number]*
Denial Reason: CO-97 / PR-96 — Out-of-Network

LETTER OF APPEAL

Dear [Insurance Company] Appeals Department,

We are appealing the denial / reduced payment on the above-referenced claim based on out-of-network (OON) provider status. We request reconsideration on one or more of the following grounds:

[SELECT ONE OR MORE ARGUMENTS BELOW]

ARGUMENT 1 — No in-network provider was available (network inadequacy): The patient required [specialty / service type] and no in-network provider was available within a reasonable distance or timeframe. Per [state law / plan terms / CMS network adequacy standards], members are entitled to in-network level benefits when the network

is inadequate to meet their needs. We request that this claim be reimbursed at the in-network benefit level. Documentation of the patient's attempts to locate an in-network provider is enclosed.

ARGUMENT 2 — Emergency services: The services were rendered on an emergency basis. Under the No Surprises Act (effective January 1, 2022) and applicable state law, emergency services must be covered regardless of network status, and cost-sharing must not exceed in-network amounts. We request that this claim be reprocessed at the in-network rate.

ARGUMENT 3 — Continuity of care: The patient was in active treatment with this provider at the time of a plan or network change. Per [state continuity of care law / plan transition policy], the patient is entitled to continue care with this provider at in-network benefit levels for [applicable transition period]. Documentation of the existing treatment relationship is enclosed.

ARGUMENT 4 — Network gap / referral by in-network provider: The patient was referred to this out-of-network provider by their in-network [PCP / specialist] because no in-network provider with the necessary expertise was available. We request in-network benefit consideration under the plan's network gap or referral exception provision.

We request that [Insurance Company] reconsider this claim and apply in-network benefits (or an appropriate OON exception). Please contact our office at [phone number] if a peer-to-peer or clinical review would assist in resolving this appeal.

ENCLOSURES

- Documentation of in-network provider search / unavailability (Argument 1)
- Emergency department records / triage notes (Argument 2)
- In-network referral documentation (Argument 4)
- Applicable state law or plan provision citation

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.