Today's Date: {Current Date}
{Visit Location}
NPI: {Visit Location NPI}

Patient: {Patient Full Name}
Subscriber Number: {Primary Member ID}
Claim Date: {Visit Admit Date} - {Visit Discharge Date}
Total Billed: {Charge Total}
Claim Number:
Re: Low Allowable Applied to Emergency Room Visit

Dear Sir or Madam:

In correspondence to {Primary Plan Name} explanation of payment for the above referenced patient, we are now requesting a 1st level appeal regarding the allowed amount utilized to process claim number {Primary ICN}.

Claims submitted for out of network providers when rendered in an emergency department are required to be processed at a ***reasonable*** of reimbursement as long as services meet medical necessity guidelines. The claim number attached to appeal was processed with an extremely low allowed amount that is not consistent with the UCR for services rendered within this geographical area.

The allowable processed by {Primary Plan Name} is (Percentage)% of {Charge Total} billed charges making the (Percentage)% remaining balance which equals to (Non-Cov Bal) patient responsibility. This is an inappropriate level of reimbursement.

The Secretaries of the Departments of Health and Human Services, Labor, and the Treasury issued regulations that require the patient's group health plan to reimburse out-of-network emergency service by paying "the greatest of three possible amounts - (1) the amount negotiated with in-network providers for the emergency service furnished; (2) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable charges); or (3) the amount that would be paid under Medicare for the emergency service.

We are asking that the above claim to be reconsidered for additional payment due to the complexity of the diagnosis in addition, medical records are enclosed.

Sincerely,

Claims Analyst
{User Full Name}
{User Email}
Direct Line: {User Phone}