

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: {Primary ICN}
Re: Case Rate Payment Applied

Dear Sir or Madam:

In correspondence to {Primary Plan Name}'s explanation of payment, we are now requesting a 2nd level appeal regarding the allowed amount utilized to process this claim.

The allowable processed by {Primary Plan Name} is (Percentage)% of {Charge Total} billed charges that equals to (Amount), making (Percentage)% remaining balance of (Non-covered Amount) patients responsibility. {Primary Plan Name} has reduced the payment of these charges due to "usual, customary, and reasonable" and/or claim has been processed using an extremely low case rate amount. This is an inappropriate level of reimbursement to the patient and provider.

Case rate reimbursement is a payment to the provider based on a pre-agreed fee that includes all aspects of care regardless of additional various costs incurred for the care but because {Visit Location} has no current agreement in-tact with {Primary Plan Name}, our claims should process according to patients In Network benefit level which lead to review of every procedure being billed prior to adjudication.

On behalf of {Primary Plan Name} customer, {Patient Name} should not be held solely responsible for the inappropriate allowance of this. {Visit Location} claim should be re-processed after thorough review of each procedure that was performed, not by case rate. Customer/patient fairness and satisfaction is what {Visit Location} is seeking.

Overview of Visit

Patient was seen at {Visit Location} with an onset of {Diagnosis Principle}

In addition, {Visit Location} has further reviewed the patient chart to ensure services that were billed met medical necessity/emergent in which, rendered services are appropriate for the level of acuity and intensity of the medical services provided and for the expertise required to provide these services.

Please see enclosed Medical Records to assist with our reconsideration of allowance for above mentioned claim. We will bill member for these services if an agreeable resolution is not achieved on this claim in 14 days.

Sincerely,

Claims Analyst

{User Full Name}

{User Email}

Direct Line: {User Phone}