[Your Name]
[Your Address Line 1]
[Your Address Line 2]
[City, State ZIP Code]
[Phone Number]
[Email Address]

[Date]

[Claims Department]
[Insurance Company Name]
[Insurance Company Address Line 1]
[Insurance Company Address Line 2]
[City, State ZIP Code]

Re: Health Insurance Claim Dispute â€“ [Claim Number / Policy Number]

Dear Sir or Madam,

I am writing to formally file a grievance regarding the denial or partial payment of my health insurance claim referenced above.

Patient Name: [Patient Full Name]
Date of Service: [Date of Service]
Provider Name: [Provider Name]
Claim Number: [Claim Number]
Policy Number: [Policy Number]

I received a notification of the denial/partial payment for the claim, with the reason stated as [insert reason provided]. I believe this dispute requires further review because [briefly explain reason for disagreement, e.g., benefits should be covered under my plan, prior authorization was obtained, medical necessity, etc.].

I have attached supporting documents for your review, including [list documentation, e.g., medical records, Explanation of Benefits, provider letters, prior authorizations, etc.].

I kindly request that you reconsider your decision and provide full coverage for the claim in accordance with my policy benefits. Please contact me if you require any additional information or documents.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name]