Your Name

Your Address

**[~Current Date~]**

Attn: Director of Claims

**[~Insurance Company Name~]**

**[~Insurance Company’s Appeal Address]**

 Re: Patient: [~Patient Name~]

 Policy: [~Insurance Policy Number~]

 ID Number: [~Unique Member ID Number~]

 Insured: [~Responsible Party Name~]

 Claim Number: [~Carrier Claim Number~]

 Treatment Date: [~Date(s) of Service~]

 Amount: [~Provider’s Total Charge~]

Dear Director of Claims,

The above referenced claim for ambulance services has been denied. It is my belief that this claim should have processed at the in-network level, with consideration up to the total charged amount, due to the inability to select an in-network provider in relation to emergency services.

Further, it is our position that the prudent layperson standard should be used as the basis for determining whether this claim falls under emergency coverage. Prudent layperson, an industry standard for the assessment of urgent medical treatment, is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the individual (or, with respect to a pregnant woman the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily organ or part.

**[~Explain series of events from date of service here. Be specific as possible.~]**

Based on this information, I am asking that you reconsider your adverse decision and allow coverage for the procedure outlined in this letter. Please contact me at xxx-xxx-xxxx if you need any additional information.

Sincerely,

[~Your Name~]