

May 20, 2026

Claims Appeals Department  
[Insurance Company Name]  
[Payer Address Line 1]  
[City, State ZIP]

RE: Formal Appeal — Claim ID CLM-1001  
Patient: Jane Martinez  
Date of Service: 2025-03-12  
Procedure Code: 99213  
Billed Amount: \$1,250.00  
Denial Reason: Medical necessity not established  
Appeal Reference: CLM-1001-20260520

To Whom It May Concern:

We are writing on behalf of Feezza Inc. and our client facility to formally appeal the denial of the above-referenced claim. This appeal is submitted in accordance with your plan's internal appeals process and applicable federal and state regulations governing claims disputes.

The services rendered meet the established criteria for medical necessity as defined under Medicare Local Coverage Determinations (LCD) and the patient's plan benefits. The treating physician documented a clear clinical indication for the procedure in the patient's medical record prior to the date of service 2025-03-12. The procedure was ordered in accordance with evidence-based clinical guidelines published by the relevant specialty society, and the patient's diagnosis supports the level of care provided under procedure code 99213. Denial on the basis of medical necessity is inconsistent with the documented clinical presentation. We respectfully request that this claim be reconsidered in light of the attached clinical notes and physician order, which together demonstrate that the service was reasonable, necessary, and appropriate for the patient's condition.

We respectfully request that this claim be reconsidered and reprocessed for payment in full within the timeframe required by applicable prompt pay regulations. Please confirm receipt of this appeal in writing and advise if any additional documentation is required to complete your review.

Sincerely,

Hospital Billing & Revenue Cycle Team  
Feezza Inc. | Wintora  
wintora.ai · legal@feezza.com  
Appeal Reference: CLM-1001-20260520

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