To: ___________________________________Insurance Carrier Name

___________________________________Address

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Re: ___________________________________Child's Name

___________________________________Identification Number

___________________________________Subscriber's Name

___________________________________Date of Service

___________________________________ Claim #

Please accept this letter as a formal request for appeal on a claim for my newborn child. My baby was born at _______________________ Hospital on ___________________ and received a state-mandated newborn hearing screening prior to discharge. MidAtlantic Neonatology Associates, P.A. (MANA) is the only group that works out of this hospital that has the equipment, personnel and professional audiology supervision to perform the screening. They do not participate in your provider network.

My child was born in a participating hospital. You did not provide me with an in-network option for the hearing screening. I am being balance billed by MANA for the amount exceeding what you consider to be reasonable and customary. I am being penalized for going out of network because you did not provide me with an in-network option from which to choose.

Please review my claim for additional payment. I have attached a copy of the most recent statement that I received from MANA. Please do not hesitate to contact me at _____________ if you require additional information. Thank you for your prompt attention.

Sincerely

_______________________________________Subscriber's Signature

_______________________________________Date

_______________________________________Address

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