Ready-to-Use Letter Templates

Two copy-paste templates referenced in "The Money That Leaves Your Practice After the Claim Is Already Paid." Fill in the bracketed details for your practice before sending.

Template 1: Stop Card Payments, Switch to Direct Deposit

Use this when a payer sends you virtual credit card (VCC) payments and you want them switched to standard electronic funds transfer (EFT) instead.

To [Payer Name] Provider Relations,

This letter is a formal request, on behalf of [Practice Name], NPI [Your NPI], Tax ID [Your Tax ID], to stop receiving claims payments via virtual credit card and to begin receiving all future payments via standard Electronic Funds Transfer (EFT) through the ACH Network, along with the associated Electronic Remittance Advice (ERA).

Per HIPAA Administrative Simplification Rules and CMS guidance, a health plan cannot require a provider to accept payment via virtual credit card, and must comply with a provider's request to use standard EFT and ERA transactions.

Please confirm in writing that this change has been made and provide the effective date for our next scheduled payment. If this request is not honored, we will file a complaint with CMS through the Administrative Simplification Enforcement and Testing Tool (ASETT).

Sincerely,
[Name, title, contact information]

Before sending: fill in the payer name, your practice name, NPI, and Tax ID. Send it in writing (email or mail) rather than only calling, so there's a record. Follow up if you don't get a written confirmation within a couple of weeks.

Template 2: Appeal a Denial by Naming the Exact Policy

Use this when a code that was previously paid without issue suddenly gets denied, and you want the payer to point to the specific rule that changed.

To [Payer Name] Appeals Department,

This letter appeals the denial of claim [claim number], for patient [patient identifier], date of service [date], billed under CPT code [code].

This code has been billed and paid without issue by this practice under the same circumstances as recently as [date of last clean payment]. We request the specific Local Coverage Determination, National Coverage Determination, or internal claims-editing policy that resulted in this denial, including its reference or version number.

Based on the documentation attached, this claim meets medical necessity and coding requirements as of the date of service. We request reprocessing of this claim, or a written explanation citing the specific policy basis for the denial if it is upheld.

Sincerely,
[Name, title, contact information]

Before sending: attach the relevant chart notes or documentation. Naming a specific policy reference (once the payer gives you one) in a follow-up appeal makes this much stronger than a general resubmission.

These templates are starting points, not legal advice. Adjust the language as needed for your practice and situation.