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PR-27 APPEAL LETTER TEMPLATE KIT

- 3 Ready-to-Use Templates
- Documentation Checklist
- Payer Submission Guidelines

Prepared by **MedSole RCM**

www.medsolercm.com

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HOW TO USE THIS APPEAL LETTER KIT

This kit contains three specialized appeal letter templates designed to address different PR-27 ("Expenses incurred after coverage terminated") denial scenarios.

CHOOSE THE RIGHT TEMPLATE

TEMPLATE A: Retroactive Termination Appeal

Use when: The Payer backdated coverage termination after you had already verified eligibility and provided services in good faith.

TEMPLATE B: Payer Data Error Appeal

Use when: The Payer's system shows an incorrect termination date that contradicts your verification or the patient's actual coverage documents.

TEMPLATE C: 2026 Medicare Advantage Retroactive Denial Appeal

Use when: A Medicare Advantage plan retroactively denied a prior-authorized inpatient admission (Citing the

new CMS rule CMS-4207-F).

BEFORE YOU SEND ANY APPEAL:

- Verify you have all supporting documentation ready.
- Check the payer's specific appeal deadline (typically 90-180 days).
- Confirm the correct appeals department mailing address or fax number.
- Make copies (digital or physical) of everything you submit.
- Ensure patient demographics match the payer's records exactly.



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TEMPLATE A — RETROACTIVE TERMINATION

[PRACTICE LETTERHEAD]

[Date]

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

RE: APPEAL OF DENIAL CODE PR-27 — RETROACTIVE TERMINATION

Patient Name:	[Patient Full Name]
Date of Birth:	[DOB]
Member ID:	[Member ID Number]
Group Number:	[Group Number]
Claim Number:	[Claim Number]
Date of Service:	[DOS]
Billed Amount:	\$[Amount]
Denial Code:	PR-27 (Expenses incurred after coverage terminated)

Dear Appeals Committee:

We are writing to formally appeal the above-referenced claim that was denied with reason code PR-27, indicating expenses were incurred after coverage terminated.

REASON FOR APPEAL:

Our practice verified the patient's eligibility on [VERIFICATION DATE] at [TIME] via [PORTAL NAME/PHONE]. At that time, coverage was confirmed as **ACTIVE** with the following details:

- Policy Status: Active
- Effective Date: [Date]
- Termination Date: None listed / [Future Date]
- Verification Confirmation #: [If available]

Services were rendered on [DOS] in good faith based on this confirmed active coverage. The retroactive termination of coverage to [TERMINATION DATE] was applied after our verification and service delivery.

SUPPORTING DOCUMENTATION ENCLOSED:

- Eligibility verification screenshot dated [Date]
- Copy of insurance card on file
- Claim submission details (UB-04/CMS-1500)
- Medical records for date of service (if required)

REQUEST:

Based on the enclosed documentation proving coverage was active at the time of verification and service, we respectfully request that:

1. This claim be reprocessed for payment.
2. The PR-27 denial be reversed.
3. Payment be issued according to our contracted rates.

Our practice followed all proper eligibility verification procedures. We should not be penalized for a retroactive coverage termination that occurred after we confirmed active status and provided care.

Please contact our billing department at [PHONE] or [EMAIL] if you require additional information.

Sincerely,

[Name]
[Title]
[Practice Name]
[NPI: XXXXXXXXXX]
[Phone]
[Email]

Enclosures: [List all attachments]



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TEMPLATE B — PAYER DATA ERROR APPEAL

[PRACTICE LETTERHEAD]

[Date]

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

RE: APPEAL OF DENIAL CODE PR-27 — PAYER SYSTEM ERROR

Patient Name:	[Patient Full Name]
Date of Birth:	[DOB]
Member ID:	[Member ID Number]
Group Number:	[Group Number]
Claim Number:	[Claim Number]
Date of Service:	[DOS]
Billed Amount:	[\$[Amount]]
Denial Code:	PR-27 (Expenses incurred after coverage terminated)

Dear Appeals Committee:

We are appealing the PR-27 denial for the above-referenced claim. Our records indicate this denial was issued in error due to incorrect termination date information in your system.

DISCREPANCY IDENTIFIED:

Your denial states coverage terminated on: **[PAYER'S TERMINATION DATE]**

Our verification on **[DATE]** showed coverage through: **[VERIFIED END DATE]**

Patient confirms coverage was active through: **[PATIENT-CONFIRMED DATE]**

The date of service (**[DOS]**) falls **BEFORE** the actual coverage termination date, making this claim payable.

EVIDENCE OF PAYER ERROR:

- Eligibility verification from **[DATE]** showing active coverage
- Patient's confirmation of coverage dates
- [If available: Employer HR confirmation of coverage dates]
- Copy of insurance card showing policy dates

REQUEST:

We request that you:

1. Review and correct the termination date in your system.
2. Reprocess this claim for payment.
3. Reverse the PR-27 denial.

Please respond within 30 days regarding the status of this appeal.
Contact our billing department at [PHONE] with any questions.

Sincerely,

[Name]

[Title]

[Practice Name]

[NPI: XXXXXXXXXX]

Enclosures: [List all attachments]

TEMPLATE C — 2026 MA RETROACTIVE DENIAL

[PRACTICE LETTERHEAD]

[Date]

[Medicare Advantage Plan Name]

[Appeals Department]

[Address Line 1]

[City, State ZIP]

RE: APPEAL OF PR-27 DENIAL — PRIOR-AUTHORIZED
INPATIENT ADMISSION
CITING 2026 MEDICARE ADVANTAGE FINAL RULE

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Medicare ID: [MBI Number]

Member ID: [MA Plan Member ID]

Claim Number: [Claim Number]

Date of Service: [Admission Date] - [Discharge Date]

Prior Auth #: [Prior Authorization Number]

Denial Code: PR-27

Dear Appeals Committee:

We are formally appealing the retroactive PR-27 denial for the above-referenced inpatient admission. This appeal is filed pursuant to the

2026 Medicare Advantage Final Rule provisions that restrict retroactive denials of previously authorized admissions.

PRIOR AUTHORIZATION WAS GRANTED:

- Prior Authorization Request Date: [Date]
- Authorization Approval Date: [Date]
- Authorization Number: [Auth Number]
- Approved Service: [Inpatient admission/procedure]
- Approved Dates: [Date range]

REGULATORY CITATION:

Per the **2026 Medicare Advantage Final Rule (CMS-4207-F)**, Medicare Advantage plans are prohibited from "reopening and modifying" previously approved inpatient admissions to issue retroactive denials.

The rule states that when prior authorization has been granted for an inpatient stay:

- The authorization approval is binding.
- Plans cannot retroactively deny based on coverage disputes discovered after approval.
- Providers who relied on the authorization in good faith are protected.

REQUEST:

Based on the 2026 Medicare Advantage Final Rule protections, we demand that:

1. The PR-27 denial be immediately reversed.
2. This claim be reprocessed for payment per the prior authorization.
3. Payment be issued within 30 days.

Failure to comply may result in escalation to CMS and filing of a formal complaint regarding MA Final Rule violations.

Sincerely,

[Name]

[Title]

[Practice Name]

[NPI: XXXXXXXXXX]

CC: [State Insurance Commissioner, if applicable]

REQUIRED DOCUMENTATION CHECKLIST

Complete this checklist before submitting any PR-27 appeal. Missing documentation is the #1 reason appeals are denied.

REQUIRED FOR ALL PR-27 APPEALS

- Completed Appeal Letter**(signed and dated)
- Copy of Original Claim** UB-04 (institutional) or CMS-1500 (professional)
 All pages, including attachments
- Explanation of Benefits (EOB) or ERA** Showing the PR-27 denial
 Include claim number and denial date
- Eligibility Verification Proof** Screenshot from payer portal (with date/time stamp)
 OR confirmation number from phone verification
- Copy of Insurance Card**(Front and back from DOS)

ADDITIONAL DOCUMENTATION BY SCENARIO

Retroactive Termination: **Payer Error:**

- Timeline showing verification vs. termination
- Evidence of correct termination date
- Payer communication about termination
- Patient/Employer confirmation

2026 MA Retroactive Denial:

- Prior auth approval letter/confirmation
- Reference to CMS-4207-F (2026 MA Final Rule)

APPEAL TRACKING LOG

Claim Number:

Date of Service:

Appeal Submitted Date:

Submission Method:

Tracking Number:

Expected Response:

Questions? Contact MedSole RCM

www.medsolercm.com

PAYER-SPECIFIC SUBMISSION GUIDELINES

MEDICARE ADVANTAGE PLANS

Appeal Deadline: 60 days from denial date

Submission: Plan-specific portal or mail

Required Form: Plan's Claim Reconsideration Form

Special Notes:

- File through MA plan first, not Original Medicare
- Cite 2026 CMS rule for retroactive denials

BLUE CROSS BLUE SHIELD (BCBS)

Appeal Deadline: 90-180 days (varies by state)

Submission: State-specific portal, fax, or mail

Special Notes:

- Each state BCBS operates independently
- Check your state's specific requirements

UNITEDHEALTHCARE (UHC)

Appeal Deadline: 180 days from denial date

Submission: UHCProvider.com portal (preferred)

Special Notes:

- Online portal submissions tracked better than fax
- Phone appeals NOT recommended (poor documentation)

AETNA

Appeal Deadline: 90 days from denial date

Submission: Availity, fax, or mail

Special Notes:

- Availity submission recommended
- Attach all documentation in single PDF when possible

GENERAL TIPS FOR ALL PAYERS

- ✓ Always get confirmation of receipt.
- ✓ Keep tracking numbers for all submissions.
- ✓ Document every phone call (date, time, rep name, reference #).

Need help with appeals?

MedSole RCM handles the entire process.

www.medsolercm.com/denial-management