Date:

Insurance Company Name
Address 1
City, State, Zip

RE: *Patient Name*
Insured: _______________
Insured ID# _______________

RE: Wisdom Teeth Extractions
Date of Procedure: ______________________

Dear Sirs,

Our patient and your client, *Mr./Ms./Mrs. Patient first and last name* was seen on *surgery date* for extraction of teeth #'s *1, 16, 17 and 32 (CDT code #'s D7220, D7230, D7240*) under intravenous sedation (CDT code D9241 and D9242). *Patient's first name* was referred to us from *his/her* general dentist, *Dr*. _________ ___________ for evaluation and possible surgical correction of impacted third molars (ICD-9 520.6).

We have submitted this claim to *Mr./Mrs./Ms. Patient last name* 's dental insurance carrier, *name of dental plan,* but they have requested a denial from *patient's first name* medical plan before they will release payment.

We respectively ask that this claim be reviewed and processed and an EOB returned at your earliest convenience so that we may forward to *Patient's dental carrier* for payment.

Thank you in advance for your prompt response in this matter, if you should need any further information, please feel free to contact me at *( )* - ____ .

Sincerely,

Office Representative
Title

Enc. *Dental EOB and HCFA 1500*