[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

Subject: Notice of Out-of-Network Billing Status

Dear [Patient Name],

This letter is to formally notify you that [Clinic Name] is currently an out-of-network provider for your health insurance plan, [Insurance Company Name].

Please be advised of the following regarding your care:

- **Insurance Coverage:** Because we are out-of-network, your insurance plan may not cover the full cost of services rendered at this clinic.
- **Financial Responsibility:** You may be responsible for the difference between our clinic's charges and what your insurance plan allows (often referred to as "balance billing").
- **Estimated Costs:** We can provide a Good Faith Estimate of the expected charges for your visit upon request.
- **Pre-Authorization:** Some insurance plans require prior authorization for out-of-network services. It is your responsibility to verify these requirements with your insurer.

We value you as a patient and want to ensure you are fully informed about your financial obligations. If you have questions regarding your specific coverage levels, please contact the member services department listed on the back of your insurance card.

If you wish to proceed with your appointment or have questions regarding our payment plans, please contact our billing office at [Phone Number].

Sincerely,

[Name/Signature]
[Title/Billing Department]
[Clinic Name]