[Your Name/Organization Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

Re: Notice of Financial Responsibility for Denied Claim

Account Number: [Account Number]
Date of Service: [Date of Service]
Claim Number: [Claim Number]

Dear [Patient/Customer Name],

We are writing to inform you that your insurance provider, [Insurance Company Name], has denied the claim for the services provided on [Date of Service].

According to the Explanation of Benefits (EOB) received from your insurer, the claim was denied for the following reason:
[Insert reason for denial, e.g., service not covered, out of network, or deductible not met].

As per our financial agreement signed on [Date], you are responsible for the balance of this claim. The total amount due is $[Amount].

Please remit payment within [Number] days of the date of this letter. You may pay by [List payment methods, e.g., check, credit card, or online portal].

If you believe this denial was made in error by your insurance company, we recommend that you contact them directly to file an appeal. However, please be advised that the balance remains your responsibility while the appeal is pending.

If you have any questions regarding this balance or wish to set up a payment plan, please contact our billing department at [Phone Number].

Sincerely,

[Your Name/Signature]
[Your Title]