[Practice Name]
[Practice Address]
[City, State, Zip Code]
[Phone Number]

[Date]

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

RE: Refund for Date of Service: [Date of Service]
Patient Account Number: [Account Number]

Dear [Patient Name],

We are writing to inform you that a recent audit of your account has identified an overpayment in the amount of $[Refund Amount].

As an out-of-network provider, we initially collected payment based on an estimate of your responsibility. Following the processing of your claim by [Insurance Company Name], it was determined that the total amount paid exceeds the balance due for the services provided on [Date of Service].

Please find the enclosed check for $[Refund Amount] representing the full reimbursement of this overpayment.

If you have any questions regarding this refund or your statement, please contact our billing department at [Phone Number] between the hours of [Hours of Operation].

Thank you for choosing [Practice Name] for your healthcare needs.

Sincerely,

[Name/Signature]
[Title]
[Practice Name]

Enclosure: Check #[Check Number]