[Date]

[Patient Full Name]
[Medicare Number]
[Street Address]
[City, State, Zip Code]

Subject: Annual Summary of Out-of-Pocket Medical Expenses for [Year]

Dear [Patient Name],

This letter provides a summary of your medical expenses and payments recorded at [Clinic/Facility Name] for the calendar year ending December 31, [Year]. This document may be useful for your personal records or tax documentation.

Date of Service	Description of Service	Total Billed Amount	Medicare Paid	Patient Out-of-Pocket
[Date]	[Service Name]	$[0.00]	$[0.00]	$[0.00]
[Date]	[Service Name]	$[0.00]	$[0.00]	$[0.00]
Total Patient Responsibility for [Year]:				**$[0.00]**

Please note that this summary only includes services provided by [Clinic/Facility Name]. It does not include prescription drug costs (Medicare Part D) paid at pharmacies or services provided by other healthcare specialists.

If you have questions regarding this summary or your account balance, please contact our billing department at [Phone Number] or [Email Address].

Sincerely,

[Staff Name/Billing Manager]
[Clinic/Facility Name]
[Phone Number]