

[Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Re: Notice of Non-Covered Services

Dear [Patient Name],

This letter is to inform you regarding the services provided to you on [Date of Service] by [Provider/Clinic Name].

Medicare has determined that the following service(s) are not covered under your current benefit plan:

- [Description of Service/Procedure] - [Cost]
- [Description of Service/Procedure] - [Cost]

Reason for Non-Coverage:

[Insert Reason, e.g., Service not medically necessary / Frequency limit exceeded / Routine screening not covered]

As per the Advance Beneficiary Notice (ABN) signed by you on [Date ABN Signed], you agreed to accept financial responsibility for these services in the event that Medicare denied payment. Therefore, the remaining balance of \$[Amount] is now due.

Please remit payment by [Due Date]. You can pay by mail using the enclosed envelope or by calling our billing office at [Phone Number].

If you believe this service should have been covered, you have the right to appeal Medicare's decision. Please refer to your Medicare Summary Notice (MSN) for instructions on how to file an appeal.

If you have any questions regarding this statement, please contact our billing department at [Phone Number].

Sincerely,

[Billing Manager Name]

[Practice/Facility Name]