[Date]

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

Subject: Out-of-Pocket Cost Estimate for Upcoming Services

Dear [Patient Name],

This letter provides an estimate of your out-of-pocket costs for the following procedure/service scheduled on [Date]:

Service: [Description of Service/CPT Code]

Estimated Cost Breakdown:

- Total Facility/Provider Charge: $[Amount]
- Medicare Allowable Amount: $[Amount]
- Estimated Medicare Coverage: $[Amount]
- **Estimated Patient Responsibility: $[Amount]**

Please note the following regarding this estimate:

- **Deductibles:** This estimate assumes your annual Medicare Part B deductible has [been met / not been met].
- **Coinsurance:** Typically, Medicare pays 80% of the approved amount, and the patient is responsible for the remaining 20%.
- **Supplemental Insurance:** If you have a Medigap or secondary insurance policy, it may cover some or all of your remaining balance.
- **Final Costs:** This is an estimate only. The final amount may vary based on the actual services provided or changes in your insurance coverage.

If you have questions regarding your Medicare benefits, please contact Medicare at 1-800-MEDICARE. For questions regarding our billing process, please call our office at [Phone Number].

Sincerely,

[Provider/Staff Name]
[Facility Name]
[Contact Information]