

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

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

Re: SECOND NOTICE - Action Required for Denied Claim
Account Number: [Account Number]
Claim Number: [Claim Number]
Date of Service: [Date of Service]
Outstanding Balance: \$[Amount]

Dear [Patient Name],

We are contacting you again regarding the insurance claim for the services provided on [Date of Service]. This is our second follow-up regarding the denial of your claim by [Insurance Company Name].

To date, we have not received notification that you have contacted your insurance provider to resolve this matter. As previously mentioned, the claim was denied because [Reason for Denial, e.g., missing information/coordination of benefits].

As the policyholder, you must take action to ensure this claim is reprocessed. Please complete the following steps immediately:

- Contact [Insurance Company Name] at [Phone Number].
- Provide them with the necessary information: [List Specific Missing Info].
- Request a reference number for your call.
- Contact our billing office at [Your Phone Number] with the update.

Please be advised that while we are assisting with the insurance process, the balance remains your responsibility. If the claim is not resolved or a payment arrangement is not made by [Date], your account may be subject to further collection actions.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name/Department Name]
[Practice Name]