

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

Re: Notice of Patient Financial Responsibility

Patient Account: [Account Number]
Date of Service: [Date of Service]
Claim Amount: \$[Total Charges]

Dear [Patient Name],

We are writing to inform you that your insurance carrier, [Insurance Company Name], has denied payment for the services provided on the date(s) listed above. The reason provided for this denial is: **Out-of-Network Provider/Services**.

According to your insurance plan, [Practice Name] is considered an out-of-network provider. As a result, the insurance company has determined that they are not responsible for the costs associated with your care at this facility.

As previously agreed upon in our financial policy, you are now responsible for the remaining balance of \$[Amount Owed].

Payment Options:

- Pay in full by [Due Date].
- Contact our billing office to set up a monthly payment plan.
- Pay online at [Website URL].

If you believe this denial was made in error by your insurance provider, we encourage you to contact their member services department immediately to file an appeal. However, please be advised that the balance remains your responsibility while any appeal is pending.

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

Sincerely,

[Billing Department Name]
[Practice Name]