

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Account Number: [Insert Account Number]

Invoice Number: [Insert Invoice Number]

Subject: ACTION REQUIRED: Payment for Non-Covered Services

Dear [Insert Patient Name],

We are writing to inform you regarding a balance on your account for services provided on [Insert Date of Service].

Your insurance provider, [Insert Insurance Company Name], has processed your claim and identified the following service(s) as "Non-Covered":

Service Description: [Insert Description of Service]

As outlined in the signed financial agreement provided at the time of your visit, patients are responsible for the cost of services that are not covered by their insurance plan. According to our records, the outstanding balance for this service is: **[\$Insert Amount Due]**.

Required Action:

Please submit your payment in full by [Insert Due Date]. You may pay your bill using one of the following methods:

- **Online:** [Insert Website URL]
- **Phone:** [Insert Phone Number]
- **Mail:** Send a check to [Insert Mailing Address]

If you believe this service should have been covered, please contact your insurance provider directly to appeal their decision. However, the balance remains your responsibility until we receive notification of a coverage change from your insurer.

If you have already made this payment, please disregard this notice. For any questions regarding this balance, please contact our billing department at [Insert Billing Phone Number].

Sincerely,

[Insert Name/Department]

[Insert Practice/Organization Name]