[Your Practice/Organization Name]
[Street Address]
[City, State, Zip Code]
[Phone Number]

[Date]

[Name of Medicare Administrative Contractor (MAC) or Auditor]
[Attention: Audit Department]
[Street Address]
[City, State, Zip Code]

RE: Response to Post-Payment Audit Request
Case/Audit ID: [Insert Audit ID Number]
Provider Name: [Insert Provider Name]
NPI: [Insert NPI Number]
Tax ID: [Insert Tax ID]

To Whom It May Concern,

Enclosed please find the complete medical chart records requested for the post-payment audit of the claims listed in your correspondence dated [Date of original request letter].

We have provided all documentation necessary to support the medical necessity, coding, and billing for the dates of service under review. The enclosed records include, but are not limited to:

- Patient demographic information
- Clinical progress notes and encounter summaries
- Physician orders and referrals
- Diagnostic test results and imaging reports
- Treatment plans and medication logs
- Signed consent forms
- Itemized billing statements

The documentation for the following patients is attached:

Patient Name	Medicare Beneficiary Identifier (MBI)	Date(s) of Service	Claim Number
[Patient 1 Name]	[MBI Number]	[MM/DD/YYYY]	[Claim #]
[Patient 2 Name]	[MBI Number]	[MM/DD/YYYY]	[Claim #]

We certify that these records are true and accurate copies of the original medical documentation. If you require further clarification or additional information regarding these files, please contact [Name of Contact Person] at [Phone Number] or [Email Address].

Thank you for your attention to this matter.

Sincerely,

[Signature]
[Printed Name]
[Title]
[Organization Name]

Enclosures: [Total Number of Pages]