

[Your Company Name/Insurance Carrier Name]  
[Mailing Address]  
[City, State, Zip Code]  
[Phone Number]

[Date]

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

**RE: Payout Breakdown and Explanation of Benefits**

Patient Name: [Patient Full Name]  
Member ID: [ID Number]  
Claim Number: [Claim Number]  
Date(s) of Service: [Start Date] to [End Date]

Dear [Provider Name],

We are writing to provide a detailed breakdown of the payment issued for the out-of-network services rendered on the dates referenced above. Please find the financial reconciliation of this claim below:

Service Date	CPT/HCPCS Code	Billed Amount	Allowed Amount	Member Responsibility	Net Payment
[Date]	[Code]	[\$[0.00]]	[\$[0.00]]	[\$[0.00]]	[\$[0.00]]
<b>TOTALS</b>		<b>[\$[0.00]]</b>	<b>[\$[0.00]]</b>	<b>[\$[0.00]]</b>	<b>[\$[0.00]]</b>

**Payment Methodology:**

The "Allowed Amount" is determined based on [Reason: e.g., Fair Health Market Data / Percentage of Medicare Reimbursement / Usual, Customary, and Reasonable (UCR) rates]. As an out-of-network provider, your reimbursement is subject to the patient's out-of-network benefit tier.

**Deductions and Adjustments:**

- Deductible Applied: \$[0.00]
- Co-insurance ( [0]% ): \$[0.00]
- Non-covered Charges: \$[0.00]

The net payment of \$[0.00] was issued via [Check/EFT] on [Date] under reference number [Reference Number].

If you wish to dispute this reimbursement or request a formal appeal, please submit a written request within [Number] days of this notice to the address listed above, including any clinical documentation supporting a higher reimbursement rate.

Sincerely,

[Sender Name]

[Title/Department]

[Contact Phone Number]