[Insurance Company Name]
[Claims Department Address]
[City, State, Zip Code]
[Phone Number]

[Date]

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

RE: EXPLANATION OF BENEFITS (EOB)

Claim Number: [Claim Number]
Policy Number: [Policy Number]
Date of Loss: [Date of Accident]
Patient Name: [Patient Name]

Dear [Policyholder Name],

This letter provides a summary of the Personal Injury Protection (PIP) benefits processed for the medical services listed below. This is not a bill.

Service Date	Provider Name	Service Description	Amount Billed	Plan Allowance	Deductible/Co-pay	Amount Paid	Remark Code
[Date]	[Provider Name]	[Service/CPT]	$[0.00]	$[0.00]	$[0.00]	$[0.00]	[Code]

PIP Benefit Summary:

- Total PIP Coverage Limit: $[Limit Amount]
- Benefits Paid to Date: $[Total Paid]
- Remaining PIP Balance: $[Remaining Balance]

Remark Code Descriptions:

[Code]: [Description of payment adjustment or denial]

If you have questions regarding these payments or if you believe an error has occurred, please contact your Claims Representative at [Phone Number].

Sincerely,

[Claims Representative Name]
[Insurance Company Name]