FINAL DEMAND NOTICE

Date: [Insert Date]
Claim Number: [Insert Claim Number]
Policy Number: [Insert Policy Number]
Total Amount Owed: $[Insert Amount]

To:
[Recipient Name]
[Recipient Address]
[City, State, Zip Code]

RE: Notice of Claim Overpayment and Request for Immediate Refund

Dear [Recipient Name],

This letter serves as a formal and final demand for the refund of a claim overpayment made to you on [Insert Date of Original Payment]. Our records indicate that you were issued a payment in the amount of $[Insert Total Paid], whereas the correct amount should have been $[Insert Correct Amount].

This overpayment occurred due to: [Insert Brief Reason, e.g., processing error, duplicate payment, or adjustment in coverage].

Despite our previous requests on [Insert Dates of Previous Notices], we have not yet received the outstanding balance of **$[Insert Overpayment Amount]**.

Please remit the full amount within [Insert Number, e.g., 10] business days from the date of this letter. Payments can be made via:

- **Check:** Payable to [Insert Entity Name] sent to [Insert Mailing Address].
- **Online/Electronic:** [Insert Instructions or Portal Link].

Failure to resolve this matter immediately may result in further action, which may include referring this account to a third-party collection agency or pursuing legal remedies to recover the funds. This may also impact your future eligibility for benefits or coverage.

If you have already sent this payment, please disregard this notice. If you have questions regarding this calculation, contact our billing department at [Insert Phone Number] or [Insert Email Address].

Sincerely,

[Your Name/Department Name]
[Company Name]
[Phone Number]