[Date]
[Patient Name]
[Address]
[City, State, Zip Code]

Subject: Notification of Partial Payment and Outstanding Balance

Dear [Patient Name],

We are writing to inform you that we have received a partial payment from your insurance provider, [Insurance Company Name], regarding your visit on [Date of Service].

Statement Summary:
Total Charges: $[Total Amount]
Insurance Payment Received: $[Insurance Amount Paid]
Insurance Adjustment: $[Adjustment Amount]
Remaining Balance Due: $[Remaining Balance]

The remaining balance is your responsibility and is due by [Due Date]. This amount may include your deductible, co-insurance, or non-covered services as determined by your insurance policy.

Please make a payment using one of the following methods:

- Online at: [Website URL]
- By phone: [Phone Number]
- By mail: Send a check to [Billing Address]

If you have already sent your payment, please disregard this notice. If you have questions regarding why your insurance did not cover the full amount, please contact your insurance carrier directly.

Thank you,

[Billing Department Name]
[Facility Name]
[Contact Phone Number]