**Date:** [Insert Date]

**Patient Name:** [Insert Patient Name]
**Account Number:** [Insert Account Number]

Dear [Insert Patient/Guarantor Name],

This letter serves as a formal notification regarding the outstanding balance for medical services provided on [Insert Date of Service] at [Insert Facility Name].

While we have submitted a claim to your insurance provider, [Insert Insurance Company Name], they have [denied the claim / applied the amount to your deductible / only issued partial payment].

Please be advised that according to our financial policy and the intake forms signed at the time of service, the ultimate responsibility for payment of all medical bills rests with the patient or the legal guarantor. Insurance coverage is a contract between you and your provider; therefore, any remaining balance not covered by insurance is your personal financial obligation.

**Total Balance Due:** $[Insert Amount]

We request that you remit payment in full within [Insert Number] days of the date of this letter. Payments can be made via:

- Online: [Insert Website Link]
- Phone: [Insert Phone Number]
- Mail: [Insert Mailing Address]

If you believe there has been an error with your insurance processing, we encourage you to contact your insurance carrier immediately. However, the balance on this account remains due to our office regardless of pending disputes with your insurer.

If you are experiencing financial hardship and need to discuss a payment plan, please contact our billing department at [Insert Phone Number].

Sincerely,

[Insert Name/Department]
[Insert Practice Name]