[Your Name]
[Your Address]
[Your Phone Number]
[Your Email Address]

[Date]

[Medical Provider Name]
[Billing Department Address]
[City, State, Zip Code]

RE: Final Balance Verification Request
Patient Name: [Patient Name]
Account Number: [Your Account Number]
Date of Service: [Date]

To Whom It May Concern,

I am writing to request a formal verification of the final balance for the account referenced above. I would like to ensure that all insurance claims have been fully processed, all contractual adjustments have been applied, and any previous payments have been credited to my account.

Please provide an itemized statement that reflects:

- The total original charges.
- The amount paid by my insurance provider.
- Any adjustments or discounts applied.
- The final remaining balance currently due.

If my account currently reflects a zero balance, please provide a written confirmation or a "paid in full" statement for my records.

Thank you for your prompt attention to this matter. I look forward to receiving this documentation within 15 business days.

Sincerely,

[Your Signature]

[Your Printed Name]