

Medical Billing Dispute Letter

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email Address]

[Billing Department Contact Name]

[Healthcare Provider/Facility Name]

[Provider Address]

[City, State, Zip Code]

Dear [Billing Department Contact Name],

I am writing to formally dispute a balance billing issue related to my medical services received on [Insert Service Date], and account number [Insert Account Number]. My insurance, [Insurance Provider Name], covered most of the amount, but I am being billed for a balance that I believe is erroneous.

The total amount billed was [Total Amount], while my insurance has informed me that my responsibility should only be [Your Expected Amount]. I have attached the Explanation of Benefits (EOB) from my insurance for your reference.

Please review my account and rectify this balance accordingly. I appreciate your attention to this matter and look forward to a timely resolution.

Thank you for your assistance.

Sincerely,

[Your Name]

Enclosures:

[List of attached documents, e.g., EOB, previous correspondence]