Medical Billing Dispute Letter

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email Address]

[Your Phone Number]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Subject: Dispute of Denied Claim #[Claim Number]

Dear [Insurance Company Representative's Name],

I am writing to formally dispute the denial of my claim #[Claim Number] submitted on [Date of Service] for [Patient's Name]. The claim was denied on [Date of Denial] with the reason stated as [Reason for Denial].

I believe this claim should be reconsidered for the following reasons:

- [Reason 1]
- [Reason 2]
- [Any supporting evidence or documentation]

I have attached copies of the relevant documents, including the Explanation of Benefits, invoices, and any other supporting materials.

Please review this dispute and provide me with a written response at your earliest convenience. If you need further information, do not hesitate to contact me.

Thank you for your attention to this matter.

Sincerely,

[Your Signature (if mailing)]

[Your Printed Name]

[Policy/Member ID Number]

[Optional: Any additional contact information]