Deductible Reconsideration Request

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

To Whom It May Concern,

I am writing to formally request a reconsideration of the deductible applied to my recent medical expenses incurred on [Insert Date(s)]. My patient account number is [Insert Account Number].

Despite my understanding of the deductible policy, I have found that my medical expenses exceed the anticipated costs and would appreciate your review of the following documents, which I have enclosed for your reference:

- Itemized bills from my healthcare provider
- Proof of payment
- Any prior communication regarding deductible adjustments

Given the circumstances of my medical situation and the financial burden it has imposed, I kindly ask for your assistance in reviewing my case. I believe that a reconsideration may lead to a more favorable outcome regarding my deductible.

Thank you for your attention to this matter. I look forward to your prompt response.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]