

# Insurance Co-Payment Details

Date: [Insert Date]

Policyholder Name: [Insert Name]

Policy Number: [Insert Policy Number]

**Dear [Policyholder Name],**

We hope this message finds you well. Below are the details regarding your co-payment for the recent healthcare services you have utilized:

## **Co-Payment Details:**

- **Date of Service:** [Insert Date]
- **Provider Name:** [Insert Provider Name]
- **Total Cost of Service:** \$[Insert Amount]
- **Your Co-Payment:** \$[Insert Co-Payment Amount]
- **Remaining Balance Covered by Insurance:** \$[Insert Remaining Amount]

For any questions or further information regarding your co-payment, please feel free to contact our customer service at [Insert Contact Information].

Thank you for choosing [Insurance Company Name]. We appreciate your trust in us.

**Sincerely,**

[Your Name]

[Your Position]

[Insurance Company Name]

[Contact Information]