Medical Bill Dispute Letter

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Subject: Dispute of Medical Bill for Out-of-Network Services

Dear [Insurance Company's Claims Department],

I am writing to formally dispute a medical bill I received related to my recent healthcare services dated [Date of Service]. The billing provider, [Provider's Name], rendered services that I believe should be covered or billed differently due to the circumstances outlined below.

Claim Number: [Claim Number]

Patient ID: [Your Patient ID]

The services provided were necessary and were not elective in nature. According to my understanding of my policy, I am entitled to receive reimbursement for out-of-network services under certain conditions. This included [specific reasons for the out-of-network care or any pre-authorization, if applicable].

Attached are copies of my medical records, the bill in dispute, and any other relevant documentation that supports my claim. I kindly request a review of my case, as well as a breakdown of the charges and the rationale behind the denial or reduction of coverage.

Thank you for your attention to this matter. I look forward to your prompt response and a fair resolution of this dispute.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]