Letter of Dispute

Your Name
Your Address
City, State, Zip Code
Email Address
Phone Number
Date: [Insert Date]

Insurance Company Name
Insurance Company Address
City, State, Zip Code

Subject: Dispute of Medical Bill Coverage

Dear [Claims Adjuster's Name],

I hope this letter finds you well. I am writing to formally dispute the recent medical bill I received for services rendered on [Date of Service] under the account number [Account Number].

The bill, totaling [Amount], has been deemed partially unpaid due to alleged issues with insurance coverage. However, I believe that these services should be covered under my policy, [Policy Number], as they were deemed medically necessary by my healthcare provider, [Provider's Name].

I respectfully request a detailed explanation for the denial or partial payment of this claim and any additional information pertinent to this dispute. Attached are copies of the bill, the insurance explanation of benefits, and relevant medical records for your review.

Please contact me at your earliest convenience so we can resolve this matter promptly. I appreciate your attention to this issue.

Sincerely,
[Your Name]

Attachments: Medical Bill, Explanation of Benefits, Medical Records