Request for Reassessment of Out-of-Network Charges

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]

Dear [Insurance Company Contact/Representative's Name],

I am writing to formally request a reassessment of the out-of-network charges incurred during my recent medical treatment at [Provider's Name] on [Date of Service]. My policy number is [Your Policy Number].

Despite prior authorization for the treatment and assurance of coverage, I was surprised to receive a bill indicating that my treatment was classified as out-of-network. I believe this classification is incorrect and would like a thorough review of my case.

Attached are copies of my medical bills, the Explanation of Benefits (EOB), and any other supporting documentation that may assist in your reassessment.

I appreciate your attention to this matter and look forward to your prompt response. Please feel free to contact me at [Your Phone Number] or [Your Email Address] should you require any more information.

Thank you for your consideration.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]