Co-Payment Notification

Date: [Insert Date]

To: [Healthcare Provider's Name]

From: [Insurance Company's Name]

Subject: Co-Payment Notification for Patient Services

Dear [Healthcare Provider's Name],

We would like to inform you that we have processed a claim for the services rendered to our member, [Patient's Name], on [Date of Service]. As per the patient's policy with us, the co-payment amount due for this visit is [Co-Payment Amount].

This co-payment is a part of the agreed terms between our company and our members and is the responsibility of the patient at the time of service.

Please ensure that this co-payment is collected from the patient during their visit. Thank you for your continued partnership in providing quality healthcare services to our members.

If you have any questions or require further information, feel free to contact us at [Contact Information].

Sincerely,

[Your Name]

[Your Position]

[Insurance Company's Name]

[Insurance Company's Address]

[Insurance Company's Phone Number]