Medical Billing Inquiry Response

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Account Number: [Insert Account Number]

Provider Name: [Insert Provider Name]

Address: [Insert Provider Address]

Phone: [Insert Provider Phone Number]

Dear [Patient's Name],

We appreciate your inquiry regarding the unpaid claims associated with your recent medical services. After reviewing your account, we have identified the following details:

- **Claim Number:** [Insert Claim Number]
- **Date of Service:** [Insert Date of Service]
- **Amount Billed:** $[Insert Amount]
- **Status:** [Insert Status e.g., Pending, Denied, etc.]

If the claim is pending, please allow [Insert Time Frame] for processing. If it has been denied, we recommend reviewing the explanation of benefits provided by your insurance company for further steps.

Should you have any additional questions or require further assistance, please do not hesitate to contact our billing department at [Insert Contact Information]. We are here to help you resolve this matter.

Thank you for your attention to this matter.

Sincerely,

[Your Name]
[Your Title]
[Provider or Practice Name]