Medical Billing Dispute Notification

Date: [Insert Date]

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

[Billing Department Name]
[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]

Dear [Billing Department/Insurance Company Name],

I am writing to formally dispute a medical bill that I received on [Insert Date of Bill] for services rendered on [Insert Date of Service]. The details of the bill are as follows:

Invoice Number: [Insert Invoice Number]
Provider Name: [Insert Provider Name]
Amount Billed: [Insert Amount Billed]

After reviewing the bill, I believe there has been an error due to [briefly explain reason for dispute, e.g., incorrect charge, services not rendered, etc.]. I kindly request that you review the details and provide clarification regarding these charges.

Attached are copies of the relevant documents, including the bill in question and any necessary medical records. Please let me know if you require any additional information.

Thank you for your attention to this matter. I look forward to your prompt response.

Sincerely,

[Your Name]