# Healthcare Bill Payment Adjustment Notice

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Account Number: [Insert Account Number]

Billing Department

[Healthcare Provider Name]

[Healthcare Provider Address]

[City, State, Zip Code]

Dear [Patient Name],

We are writing to inform you of an adjustment made to your recent healthcare bill dated [Insert Bill Date]. After reviewing your account, we have identified changes that affect the total amount due.

**Original Amount Due:** $[Original Amount]

**Adjusted Amount Due:** $[Adjusted Amount]

**Adjustment Description:** [Brief description of the adjustment]

If you have any questions regarding this adjustment or require further assistance, please do not hesitate to contact our billing department at [Insert Contact Number] or [Insert Contact Email].

We appreciate your understanding and continued trust in our healthcare services.

Sincerely,

[Your Name]

[Your Title]

[Healthcare Provider Name]