MEDICAL BILL ERROR DISPUTE STATEMENT

SENDER / PATIENT NAME

ADDRESS

PHONE NUMBER

EMAIL ADDRESS

DATE

BILLING ENTITY / PROVIDER NAME

BILLING DEPARTMENT ADDRESS

ACCOUNT / MEMBER NUMBER

PATIENT & INSURANCE INFORMATION

PATIENT FULL NAME

INSURANCE PROVIDER NAME

PATIENT DATE OF BIRTH

POLICY ID / GROUP NUMBER

DISPUTED STATEMENT DETAILS

INVOICE / STATEMENT NUMBER

DATE OF SERVICE

TOTAL AMOUNT BILLED

TOTAL DISPUTED AMOUNT

SPECIFICATION OF BILLING ERRORS

DATE OF SERVICE	CPT / PROCEDURE CODE	DESCRIPTION OF ERROR / DISCREPANCY	DISPUTED AMOUNT

DETAILED EXPLANATION OF DISPUTE

I am formally disputing the charges outlined above. I request a review of this account and correction of the identified errors. Please suspend any collection activities on these disputed amounts while this inquiry is pending. Please provide a written response within the standard statutory period detailing the outcome of your review and, if applicable, an updated, corrected itemized statement.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

DATE SIGNED