

MEDICAL DISPUTE LETTER

Patient Name: _____ Patient ID / DOB: _____

Healthcare Provider Name: _____

Healthcare Provider Address: _____

Insurance Company: _____

Claim / Policy Number: _____

Subject:

Formal Medical Dispute Regarding Claim Denial or Billing Inaccuracy

1. Introduction

This letter serves as a formal dispute regarding the medical claim identified above. The undersigned patient and/or authorized representative hereby dispute the denial, reduction, or inaccuracy of the medical billing or insurance claim and request thorough review and correction as applicable.

2. Patient and Treatment Details

The patient named above received medical services from the healthcare provider specified herein. Services rendered were medically necessary and appropriately documented. The details of the services include, but are not limited to, diagnosis codes, procedure codes, dates of service, and treating practitioner information.

3. Grounds for Dispute

The denial, reduction, or billing discrepancy is based on one or more of the following grounds: incorrect coding, lack of prior authorization, failure to recognize covered services, clerical errors, or other administrative inaccuracies.

Supporting documentation is attached or will be provided upon request.

4. Request for Review and Resolution

We hereby request a comprehensive review of the claim, consideration of all relevant documentation, and correction or reversal of any erroneous denials or adjustments. Prompt and fair resolution consistent with applicable laws, regulations, and contractual provisions is requested.

5. Legal and Regulatory Compliance

This dispute is submitted in good faith and in accordance with all relevant federal and state laws, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act (ACA), and applicable state insurance regulations. The rights of all parties are expressly reserved.

6. Privacy and Confidentiality

All personal health information and related documents provided as part of this dispute shall be handled in compliance with HIPAA and any other applicable privacy laws and regulations. Unauthorized disclosure is strictly prohibited.

7. Contact Information

Please direct all correspondence regarding this dispute to the following contact: [Insert Contact Name], [Insert Relationship to Patient], at [Insert Phone Number], [Insert Email Address], and/or mailing address as provided above.

8. Documentation Enclosed

Enclosed with this letter are copies of relevant medical records, billing statements, explanation of benefits (EOB), correspondence, and any other supporting evidence necessary to substantiate this dispute.

9. Reservation of Rights

The undersigned reserves all rights to pursue further administrative, legal, or equitable remedies available under applicable law should this dispute not be resolved satisfactorily.

10. Signature and Authorization

The undersigned certifies that the information contained herein is accurate to the best of their knowledge and that they are authorized to submit this dispute on behalf of the patient.

Authorized Representative Signature

Healthcare Provider Signature

Signature: _____

Signature: _____

Print Name: _____

Print Name: _____

Date: _____

Date: _____

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