[Patient Name]
[Patient Address]
[City, State, Zip Code]
[Phone Number]

[Date]

[Billing Department/Collection Agency Name]
[Company Address]
[City, State, Zip Code]

RE: Confirmation of Patient Responsibility / Formal Investigation Request

Account Number: [Account Number]
Date of Service: [Date of Service]
Total Amount Billed: $[Amount]

To Whom It May Concern,

I am writing to formally request a detailed investigation and confirmation of the outstanding balance associated with the account mentioned above. I am seeking to verify my exact financial responsibility for this debt before proceeding with payment.

Please provide the following documentation to confirm the validity and accuracy of this debt:

- An itemized statement listing all services rendered, codes used, and individual costs.
- An Explanation of Benefits (EOB) from my insurance provider showing what was paid, what was adjusted, and the specific amount designated as "Patient Responsibility."
- Verification that all applicable secondary insurances or financial assistance programs have been applied.
- Written proof that this debt is not a result of "balance billing" or a violation of the No Surprises Act.

I am disputing the current balance until this information is provided and verified. Please cease any collection efforts or reporting to credit bureaus regarding this specific account while this investigation is pending.

I look forward to receiving the requested documentation within 30 days of your receipt of this letter. Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]