

{Patient Full Name}

{Patient Home Address 1}

{Patient Home City}, {Patient Home State} {Patient Home Zip Code}

REQUEST FOR ADDITIONAL INFORMATION

account #: {GoRev Account Number}

dos: {Visit Admit Date}

billed amount: \$ {Charge Total}

Dear {Patient First Name},

In order to bill your insurance company, {Facility} needs additional insurance information. Please contact our Patient Accounts Department at {Statement Phone Number} or fax a copy of your insurance information to 713-474-1562. Please include your name and the facility you were seen at, or attach this letter with your fax.

The balance of \$ {Charge Total} is your responsibility until information is received and verified.

Sincerely,

Claims Analyst

{User Full Name}

{User Email}

Direct Line: {User Phone}