

The Medical Bill Fight Kit

8 Fill-In-The-Blank Templates to Dispute, Appeal, Negotiate & Resolve Any Medical Bill

A comprehensive guide to help you navigate medical billing disputes

Insurance Coverage Statements

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5	Meder-Meng Wrtoler Gaig	76.00		153.50	\$10.00
6	Besting Coverage	27.00		\$44.00	710.00
7	Monty	77.00		\$23.00	\$15.00
8	Insturo Coverage Coeange	87.00		\$10.00	\$10.00
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Legal Disclaimer & How to Use This Kit

Important Legal Disclaimer

This product is provided for general informational and educational purposes only. It does not constitute legal, financial, or medical advice. It is not a substitute for the advice of a licensed attorney, financial advisor, or other qualified professional.

Purchase or use of this product does not create an attorney-client relationship. This kit is not provided by a law firm and does not constitute legal representation.

Laws regarding¹ medical billing, debt collection, insurance appeals, and consumer rights vary significantly by state and individual circumstance. Templates may not reflect current laws in your jurisdiction.

This product does not guarantee any specific outcome in any billing dispute, insurance appeal, or debt collection matter. You assume full responsibility for any actions taken based on the information provided.

Before taking action, we strongly recommend consulting a licensed attorney in your state or a certified patient advocate.

How This Kit Works

This kit contains 8 fill-in-the-blank templates. Each one is designed for a specific stage of the medical bill dispute process. You do not need to use all 8 — start with the template that matches your current situation.

Step 1: Turn to the Decision Flowchart (next card) to identify which template(s) you need.

Step 2: Fill in your personal details in the bracketed fields [like this].

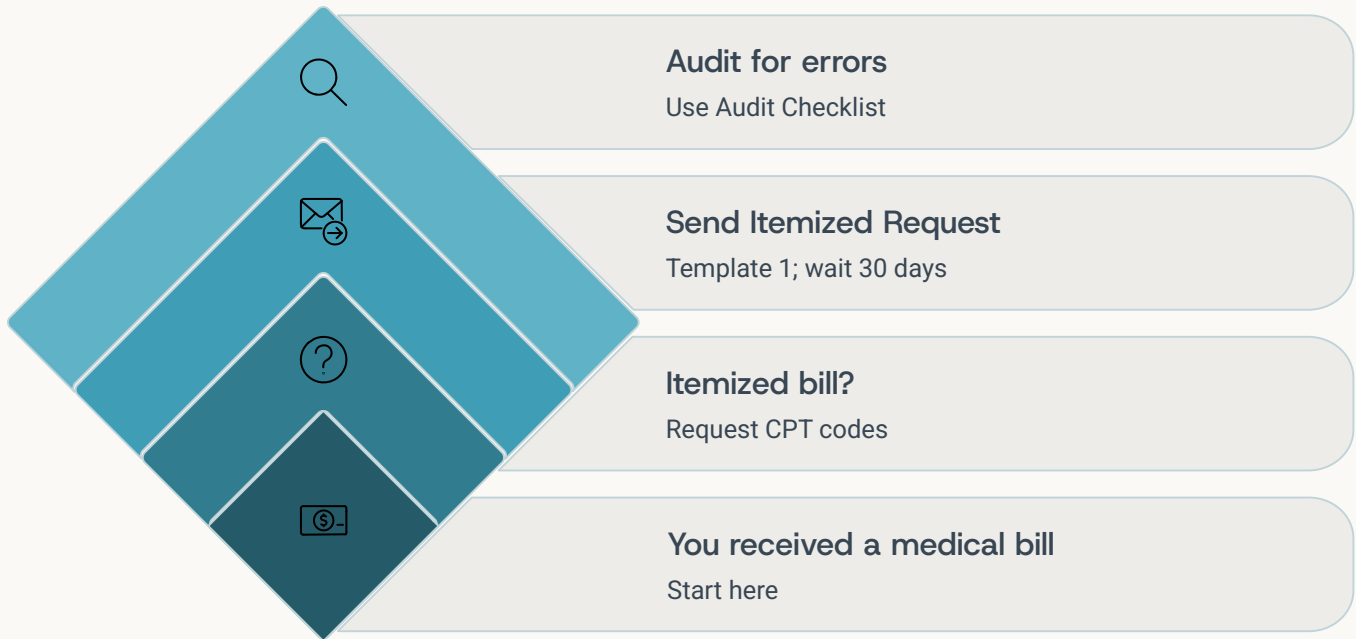
Step 3: Send the letter via certified mail with return receipt requested (recommended) or email with read receipt.

Step 4: Use the Documentation Tracker (final cards) to log every interaction.

Every template includes the legal citations and specific language that hospitals, insurers, and collectors are required to respond to. You do not need legal or medical knowledge to use them.

Decision Flowchart: I Got a Medical Bill. Now What?

Follow this path to determine which templates you need and what deadlines apply to your situation.



Itemized Bill Request

30 days response time under HIPAA

Internal Insurance Appeal

180 days from denial to file

External Review

4 months from final internal denial

Financial Assistance

240 days from first bill

Debt Validation

30 days from collector notice

No Surprises Act

120 days from bill date

Template 1: Itemized Bill Request Letter

Use this FIRST. You cannot dispute what you cannot see.

When to use: You received a medical bill that shows only a total amount or summary charges — not a line-by-line breakdown with procedure codes.

Why it works: Under HIPAA (45 CFR § 164.524), you have the legal right to access your billing records. Hospitals must respond within 30 calendar days. This letter creates a formal paper trail and puts the provider on notice that you are reviewing charges.

[Your Full Name]
[Your Street Address]
[City, State, ZIP]
[Your Phone Number]
[Your Email Address]
[Today's Date]

[Hospital/Provider Name]
Billing Department
[Hospital Street Address]
[City, State, ZIP]

RE: Request for Itemized Bill and Billing Records

Patient Name: [Your Full Legal Name]
Date of Birth: [MM/DD/YYYY]
Account Number: [From your bill]
Date(s) of Service: [MM/DD/YYYY – MM/DD/YYYY]

Dear Billing Department:

Pursuant to my rights under the HIPAA Privacy Rule (45 CFR § 164.524), the Affordable Care Act (Section 2718(e)), and [Your State] law, I am formally requesting a complete itemized bill for all services provided during the above-referenced dates of service.

I am requesting the following documents:

1. A fully itemized billing statement including, for each line item: date of service, description of service/procedure/medication/supply, CPT and/or HCPCS codes, ICD-10 diagnosis codes, revenue codes, quantity, individual unit price, and total charge per line item.
2. A copy of the UB-04 claim form(s) submitted to my insurance company (if applicable).
3. A copy of any Explanation of Benefits (EOB) received from my insurer related to this account.

Please deliver these records via [email at the address above / mail to the address above / my patient portal].

Under HIPAA, you are required to fulfill this request within 30 calendar days of receipt. I expect these documents no later than [date – 30 days from today].

I am reviewing the accuracy of charges on this account and will not make payment until I have received, reviewed, and verified the itemized charges. This is not a refusal to pay — it is a good-faith request for documentation to which I am legally entitled.

If this request is not fulfilled within the required timeframe, I will file a formal complaint with the [Your State] Department of Insurance, the HHS Office for Civil Rights, and CMS.

Sincerely,

[Your Printed Name]

Instructions: Send via certified mail, return receipt requested. Keep a copy for your records. If no response within 2 weeks, call the billing department every 3–4 days. Log every interaction in the Documentation Tracker.

Template 2: Medical Bill Audit Checklist

80% of medical bills contain errors. Use this checklist to find them.

Instructions: Once you receive your itemized bill (Template 1), check every line item against this list. Mark any item that looks incorrect – each marked item becomes the basis for your dispute letter (Template 3).

Section A: Check for These 8 Common Errors

- **Duplicate charges** – Same CPT code appearing twice on the same date. Common with blood draws, imaging, and medication doses.
- **Upcoding** – A higher-cost procedure code than the service you actually received. Example: ER visit coded as Level 5 (CPT 99285) when your visit was Level 3 (CPT 99283).
- **Unbundling** – Services that should be billed as one bundle are split into separate charges. Example: A Comprehensive Metabolic Panel (CPT 80053) billed as 14 individual lab tests.
- **Charges for services not received** – Medications you were never given, tests never performed, procedures that didn't happen. Cross-reference against your memory and medical records.
- **Incorrect patient information** – Wrong name, date of birth, insurance ID, or account number. These errors can cause someone else's charges to appear on your bill.
- **Wrong diagnosis or procedure codes** – ICD-10 or CPT codes that don't match the services in your medical records. 32% of claim denials are coding-related.
- **Balance billing errors** – Being charged the difference between the provider's price and your insurer's allowed amount. Prohibited for in-network providers and for emergency services under the No Surprises Act.
- **Pharmacy markups** – Hospital pharmacy prices can exceed retail costs by 500–10,000%. Compare any medication charges to retail prices at GoodRx.com or the CMS NADAC database.

Section B: Verify Each Line Item Category

- **Room & board** – Correct number of days? No charges after your discharge date? Correct room type (private vs. shared)?
- **Medications** – Every medication name, quantity, and dosage matches what you actually received?
- **Supplies** – Watch for absurd markups on basic items (gowns, gloves, tissue boxes).
- **Physician fees** – Attending, surgeon, anesthesiologist, radiologist, pathologist – verify each one was involved in your care.
- **Lab/pathology charges** – Check for unbundled panels. Were all tests actually ordered?
- **Radiology/imaging** – Verify every X-ray, CT, MRI, or ultrasound billed actually occurred.
- **Anesthesia** – Billed in time units. Compare against your surgical records for actual duration.
- **Operating room time** – Billed in increments. Verify against actual procedure length.
- **ER level** – Coded Level 1–5 (CPT 99281–99285). Higher level = more expensive. Does the level match the severity of your visit?

- Compare Prices:** Use FAIR Health Consumer ([fairhealthconsumer.org](https://www.fairhealthconsumer.org)), CMS Medicare Fee Schedule ([cms.gov/medicare/physician-fee-schedule/search](https://www.cms.gov/medicare/physician-fee-schedule/search)), and Healthcare Bluebook ([healthcarebluebook.com](https://www.healthcarebluebook.com)) to check whether you're being charged a fair amount. Hospital chargemaster prices average 3.5× actual costs.

Template 3: Medical Bill Dispute Letter

When you've found errors in your itemized bill

When to use: You have completed the Medical Bill Audit Checklist (Template 2) and identified specific errors, duplicate charges, incorrect codes, or services you did not receive.

Why it works: This letter formally notifies the provider of billing errors and requires them to investigate and correct the charges. It creates a documented dispute that prevents the bill from being sent to collections while under review.

[Your Full Name]

[Your Street Address]

[City, State, ZIP]

[Your Phone Number]

[Your Email Address]

[Today's Date]

[Hospital/Provider Name]

Billing Department

[Hospital Street Address]

[City, State, ZIP]

RE: Formal Dispute of Medical Bill – Billing Errors Identified

Patient Name: [Your Full Legal Name]

Account Number: [Account Number]

Date(s) of Service: [MM/DD/YYYY]

Dear Billing Department:

I am writing to formally dispute charges on the above-referenced account. After reviewing the itemized bill I received on [date], I have identified the following errors:

[List each error specifically. For each one, include: the line item number or date, the CPT/procedure code, the charge amount, and why it is incorrect.

Examples:]

- Line item 12, Date [MM/DD/YYYY], CPT code 85025 (Complete Blood Count), charged twice on the same date – $\$[\text{amount}] \times 2 = \$[\text{total}]$. I only had one blood draw performed.
- Line item 34, Date [MM/DD/YYYY], CPT code 99285 (Emergency Department Visit, Level 5), charged $\$[\text{amount}]$. My visit was for [minor complaint] and did not involve life-threatening conditions. This should be coded as Level 3 (CPT 99283).
- Line item 56, Date [MM/DD/YYYY], Acetaminophen 500mg, charged $\$[\text{amount}]$ per tablet. Retail price is $\$[\text{amount}]$. This represents a markup of [X] %.

I am requesting that these charges be corrected and a revised bill issued within 30 days. The total amount in dispute is $\$[\text{sum of disputed charges}]$.

Under the Fair Credit Billing Act and applicable state law, I am not obligated to pay disputed charges while this matter is under investigation. Please place a hold on this account and do not send it to collections or report it to credit bureaus until these errors are resolved.

Please send me a written response explaining how each disputed item was resolved, along with a corrected itemized bill.

Sincerely,

[Your Printed Name]

- Instructions:** Send via certified mail with return receipt requested. Keep copies of your original itemized bill with errors marked. If the hospital does not respond within 30 days, follow up in writing and escalate to your state's Department of Health or Attorney General's consumer protection division.

Template 4A: Insurance Appeal Letter – Internal Appeal

20% of claims are denied. Less than 1% are appealed. But 44–80% of appeals succeed.

When to use: Your health insurance denied a claim. You received an Explanation of Benefits (EOB) or denial letter stating the service was not covered, not medically necessary, required prior authorization, was out-of-network, or was experimental/investigational.

Deadline: You must file within 180 days of receiving the denial. The insurer must decide within 30 days (pre-service) or 60 days (post-service). For urgent care: request expedited review – decision within 72 hours.

[Your Full Name]
[Your Street Address]
[City, State, ZIP]
[Your Phone Number]
[Your Email Address]
[Today's Date]

[Insurance Company Name]
Appeals Department
[Insurance Company Address]
[City, State, ZIP]

RE: FORMAL INTERNAL APPEAL – Claim Denial

Member Name: [Your Full Legal Name]
Member ID: [Your Insurance Member ID]
Group Number: [if applicable]
Claim Number: [From your denial letter/EOB]
Date of Service: [MM/DD/YYYY]
Provider: [Doctor or Hospital Name]
Denied Service: [Procedure/treatment/medication name]

Dear Appeals Department:

I am writing to formally appeal the denial of the above-referenced claim, pursuant to my rights under the Affordable Care Act (PHS Act § 2719) and 45 CFR § 147.136.

THE DENIAL

On [date], I received a denial letter / Explanation of Benefits stating that [procedure/treatment] was denied. Your stated reason was:

"[Copy the EXACT denial language from your EOB or denial letter here]"

WHY THIS DENIAL SHOULD BE REVERSED

[Insert your specific argument based on your denial reason. If denied for "not medically necessary," explain why the treatment is medically necessary according to clinical guidelines and your physician's letter. If denied for "prior authorization not obtained," explain the emergency circumstances or that authorization was obtained. If denied as "out of network," cite the No Surprises Act protections. If denied as "experimental/investigational," cite FDA approval and peer-reviewed studies.]

This determination contradicts current clinical guidelines published by [relevant medical society], which recommend [treatment] for patients with [your condition/symptoms]. My treating physician, Dr. [Name], has provided the attached Letter of Medical Necessity confirming that [treatment] is medically necessary based on my diagnosis of [ICD-10 code and condition name], the severity of my condition, and the fact that [prior treatments tried] have been insufficient.

Pursuant to 29 CFR § 2560.503-1 and 45 CFR § 147.136, I request copies of all internal rules, guidelines, protocols, and medical policies applied in making this adverse benefit determination.

SUPPORTING DOCUMENTATION ENCLOSED

1. Copy of the denial letter / EOB dated [date]
2. Complete medical records for dates of service
3. Letter of Medical Necessity from Dr. [Name]
4. [Peer-reviewed studies / clinical guidelines / FDA documentation]
5. [Any other supporting materials]

REQUEST

I respectfully request that you reverse this denial and approve coverage for [treatment/procedure]. Please provide your written decision within the timeframe required under 45 CFR § 147.136.

If this internal appeal is denied, I will exercise my right to file for an external review with an Independent Review Organization, as guaranteed under federal law.

Sincerely,

[Your Printed Name]



Instructions: Send via certified mail with return receipt AND via the insurer's online portal (if available). Ask your treating physician for a Letter of Medical Necessity – this is the single most important supporting document. Keep copies of EVERYTHING you send. If denied internally → proceed to Template 4B (External Appeal). For urgent/expedited situations, call the insurer and request a 72-hour expedited review.

Template 4B: External Appeal to Independent Review Organization

If your internal appeal was denied, federal law guarantees you an independent review. The decision is BINDING on your insurer.

When to use: Your internal appeal (Template 4A) was denied. You have exhausted internal appeals, or your denial was for experimental/investigational treatment (which can go directly to external review).

Deadline: File within 4 months of your final internal denial. Decision within 45 days (standard) or 72 hours (expedited). Filing is free under the federal process or costs a maximum of \$25 under state processes (refunded if you win).

How to file: Contact your state Department of Insurance or file at externalappeal.cms.gov / call 1-888-866-6205.

[Your Full Name]

[Your Address]

[Today's Date]

[State Department of Insurance / External Review Entity]

[Address]

RE: Request for External Review of Health Insurance Claim Denial

Member Name: [Your Full Legal Name]

Member ID: [Insurance Member ID]

Insurance Company: [Name]

Claim Number: [Number]

Date of Service: [Date]

Internal Appeal Denial Date: [Date of final internal denial]

Dear External Review Administrator:

I am requesting an independent external review of the above-referenced claim denial, pursuant to my rights under the Affordable Care Act (PHS Act § 2719 and 45 CFR § 147.136).

I filed an internal appeal with [Insurance Company] on [date]. The internal appeal was denied on [date]. I have attached copies of the original denial, my internal appeal, and the internal appeal denial.

REASON FOR EXTERNAL REVIEW

[Insurance Company] denied [treatment/procedure] on the grounds that [quote exact denial reason]. I believe this denial is incorrect because [brief summary of your argument – refer to the full argument in your internal appeal letter].


ENCLOSED DOCUMENTS

1. Original denial letter (dated [date])
2. My internal appeal letter (dated [date])
3. Internal appeal denial letter (dated [date])
4. Complete medical records
5. Letter of Medical Necessity from Dr. [Name]
6. Supporting clinical evidence
7. [Any additional documentation]

I request that an Independent Review Organization evaluate this denial and issue a binding determination. If expedited review is available, I request it due to [urgency of treatment / ongoing harm from delay].

Sincerely,

[Your Printed Name]

 **Instructions:** The IRO is independent – no financial ties to your insurer. Their decision is legally BINDING on the insurance company. You can submit new evidence that was not included in the internal appeal. If you win, the insurer must cover the service. Contact the CMS No Surprises Help Desk for assistance: 1-800-985-3059.

Template 5: Medical Bill Negotiation Phone Script

93% of people who negotiate their medical bills get them reduced. Average savings: \$1,500–\$3,000.

Before you call: Have your itemized bill in front of you. Look up what Medicare pays for your main procedures at [cms.gov/medicare/physician-fee-schedule/search](https://www.cms.gov/medicare/physician-fee-schedule/search). Check fair market prices at [fairhealthconsumer.org](https://www.fairhealthconsumer.org). Have paper and pen ready to document the call (name, time, reference numbers). Know your total – and know the number you want to reach.

01

Opening

"Hello, my name is [Name]. I recently received a bill for treatment on [date], account number [number]. I'd like to discuss this bill and explore options for reducing the amount I owe. Can you connect me with someone who handles billing adjustments or financial assistance?"

03

Request Self-Pay Discount

"What is your self-pay or cash-pay discount?" Most providers offer 25–35% for paying without insurance or paying the full balance directly.

05

Anchor to Medicare Rates

"I looked up the Medicare rate for this procedure on the CMS fee schedule. It's \$[amount]. Can you match or come close to that rate?" This is your most powerful anchor. Medicare rates are what the government considers fair.

07

Negotiate Payment Plan

"Can I set up a zero-interest payment plan? What is the longest plan you offer?" Only ask this AFTER negotiating the total down. Never agree to a plan at the original amount.

Closing: Get It in Writing

"Before I make any payment, I need the agreed terms in writing – the total amount, that this constitutes payment in full, and that no remaining balance will be sent to collections or reported to credit bureaus. Can you email or mail that to me?"

⚠ DO NOT PAY UNTIL YOU HAVE THE AGREEMENT IN WRITING.

02

Ask About Financial Assistance

"Do you have a financial assistance or charity care program? Can you send me an application?" Even if they say no, this signals you know about the program and primes the conversation.

04

Request Prompt-Pay Discount

"What is your prompt-pay discount if I settle the full balance today?" Typical range: 10–30%. Some hospitals offer up to 50%.

06

Ask About Cash Price

"What is the cash price for this service under your price transparency requirements?" Hospitals are legally required to publish these prices. If their cash price is lower than your bill, point it out.

08

Make Settlement Offer

"I see the balance is \$[amount]. I can pay \$[your offer – typically 30–50% of the total] today to settle this account at a zero balance. Can you accept that?" If they say no: "What's the lowest amount you'd accept today to close this account?"

What NOT to Say

- "I'll pay whatever you need"
- "Let me put it on my credit card"
- "I can't afford this" (as first statement)
- Never agree to payment plan before negotiating
- Never give bank info to collectors over phone

Template 6: Financial Hardship / Charity Care Letter

Every nonprofit hospital in the US is legally required to offer financial assistance.

When to use: You cannot afford your hospital bill and the hospital is a nonprofit (tax-exempt 501(c)(3)) organization. Check if your hospital is nonprofit at dollarfor.org.

Why it works: Under IRS Section 501(r), nonprofit hospitals must maintain a Financial Assistance Policy, accept applications for 240 days, and cannot pursue collections for at least 120 days. Failure to comply risks their tax-exempt status. 67% of properly prepared applications are approved.

200%

Free Care Threshold

Federal Poverty Level — households below this typically qualify for free care

400%

Discounted Care

Federal Poverty Level — households below this typically qualify for discounted care

67%

Success Rate

Of properly prepared charity care applications are approved

2025 Federal Poverty Level — Do You Qualify?

Household Size	200% FPL (Free Care Typical)	400% FPL (Discounted Care Typical)
1 person	\$31,300	\$62,600
2 people	\$42,300	\$84,600
3 people	\$53,300	\$106,600
4 people	\$64,300	\$128,600

If your household income is below the 200% column, you likely qualify for FREE care. If below the 400% column, you likely qualify for DISCOUNTED care. These are typical thresholds — individual hospital policies vary. Check your hospital's specific policy at dollarfor.org.

[Your Full Name]
[Your Address]
[Phone / Email]
[Today's Date]

[Hospital Name]
Financial Assistance Office
[Hospital Address]

RE: Request for Financial Assistance

Patient Name: [Your Full Legal Name]
Account Number: [Number]
Date(s) of Service: [Dates]
Total Amount Billed: \$(Amount)

Dear Financial Assistance Office:

I received treatment at your facility on [date(s)] and am writing to request financial assistance under your hospital's Financial Assistance Policy, as required under Section 501(r) of the Internal Revenue Code.

Due to [explain your specific hardship — job loss / reduction in hours / unemployment since date / medical condition that has limited ability to work / family emergency / fixed income / retirement / disability / other specific circumstance], my current household income is approximately \$[annual amount] for a household of [number] people. This places my household at approximately [X]% of the Federal Poverty Level.

Carrying this medical bill on top of my existing financial obligations has made it difficult to afford basic necessities including housing, food, utilities, and transportation.

Monthly Household Summary

- Gross monthly income: \$_____
- Rent / mortgage: \$_____
- Utilities: \$_____
- Food: \$_____
- Transportation: \$_____
- Other medical expenses: \$_____
- Insurance premiums: \$_____
- Minimum debt payments: \$_____
- **Total monthly expenses: \$_____**

Supporting Documentation Enclosed

- Most recent federal tax return (or tax transcript)
- Recent pay stubs / proof of income (past 2–3 months)
- Bank statements (past 2–3 months)
- Copy of medical bills for this account
- Unemployment benefits letter (if applicable)
- Disability/Social Security award letter (if applicable)

I am requesting [full forgiveness / a reduction] of my medical bill under your financial assistance policy. I understand that as a tax-exempt nonprofit hospital, you are required under 26 U.S.C. § 501(r)(4)–(6) to maintain and widely publicize a financial assistance program and to determine my eligibility before pursuing extraordinary collection actions.

Thank you for your consideration. Please contact me at [phone/email] if you need additional information.

Sincerely,

[Your Printed Name]

- ☐ **Instructions:** You have 240 days from your first bill to apply — but apply as soon as possible. The hospital cannot send your bill to collections for at least 120 days. If denied, ask for the specific reason in writing and reapply with additional documentation. Free help with applications: dollarfor.org (has helped eliminate \$131M+ in medical debt).

Template 7: Debt Collector Validation & Cease Letter

If a debt collector contacts you, they must prove the debt is valid. If they can't, they must stop collecting — by law.

When to use: A debt collection agency has contacted you (by phone, letter, or credit report) about a medical bill. You have 30 days from receiving their first written notice to send this letter.

Why it works: The Fair Debt Collection Practices Act (15 USC § 1692g) requires collectors to validate the debt upon written request. They must cease ALL collection activity — including calls, letters, and credit reporting — until they provide full verification. If they cannot validate, they must stop permanently.

⚠️ CRITICAL: Do NOT make any payment or verbally acknowledge the debt before sending this letter. Partial payment may restart the statute of limitations in your state.

[Your Full Name]
[Your Address]
[Today's Date]

[Debt Collector Name]
[Debt Collector Address]

RE: Account No. [Number from collection notice]
SENT VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Dear Sir/Madam:

I am writing in response to your [letter/call] dated [date] regarding the above-referenced account. I am exercising my rights under the Fair Debt Collection Practices Act, 15 U.S.C. § 1692g, and Regulation F, 12 C.F.R. § 1006.34, to dispute this debt in its entirety and request validation.

Pursuant to 15 U.S.C. § 1692g(b), you are required to cease all collection activities until you have provided the requested verification.

Please provide the following:

1. Proof of the Debt

- A copy of any signed agreement or contract between myself and the original creditor
- Complete payment history showing all charges, payments, credits, interest, and fees
- Itemized statement of the amount claimed, including charges by date of service, billing code, and amount (per 12 C.F.R. § 1006.34(c)(2))

2. Chain of Assignment

- Name and address of the original creditor (per 15 U.S.C. § 1692g(a)(5))
- Documentation showing chain of assignment from original creditor to your agency
- Proof of authorization to collect this debt in [your state]

3. Validation of Amount

- Itemization of debt on the itemization date and current balance (per 12 C.F.R. § 1006.34(c)(2)(vi)–(ix))
- Explanation of all interest, fees, and charges added to the original amount
- Proof the amount has not already been paid by insurance or other party
- Proof charges comply with applicable law, including the No Surprises Act (P.L. 116-260)

4. For Medical Debt Specifically

- Healthcare provider name, dates of service, and services rendered
- Proof the underlying charges were not subject to financial assistance required under 26 U.S.C. § 501(r)(4)–(6)
- Proof all applicable insurance was billed and this amount represents only my verified patient responsibility

PLEASE BE ADVISED:

- Under 15 U.S.C. § 1692g(b), you must cease all collection activity until verification is provided.
- You may not report this debt without noting it as disputed (15 U.S.C. § 1692e(8)).
- If you cannot validate this debt, you must cease all collection activity and remove any credit reporting related to this account.
- Continued collection without proper verification constitutes a violation of the FDCPA, for which I may pursue statutory damages of up to \$1,000 per action, actual damages, and attorney's fees under 15 U.S.C. § 1692k.
- Per the CFPB Advisory Opinion on Medical Debt Collection (89 FR 80715), collectors must have a "reasonable basis" for asserting debts are valid.

This letter is not an acknowledgment of the debt. I am disputing it in its entirety and reserving all rights under the FDCPA, FCRA, and applicable state law.

Sincerely,

[Your Printed Name]

Instructions: MUST be sent within 30 days of receiving the collector's first notice. ALWAYS send via certified mail with return receipt requested. NEVER make a payment before sending this letter. NEVER verbally acknowledge that you owe the debt. If the collector continues contacting you after receiving this letter without providing validation, document every contact — each one is a potential FDCPA violation worth up to \$1,000 in statutory damages.

Template 8: No Surprises Act Dispute Letter

Federal law protects you from surprise out-of-network bills and bills that exceed your Good Faith Estimate by \$400 or more.

When to use (choose one):

- You received an out-of-network bill for emergency services
- You received an out-of-network bill from a provider at an in-network facility (anesthesiologist, radiologist, pathologist, etc.)
- You are uninsured/self-pay and your final bill exceeds the Good Faith Estimate by \$400+

[Your Full Name]

[Your Address]

[Today's Date]

[Provider / Hospital Billing Department]

[Address]

RE: Dispute Under the No Surprises Act (P.L. 116-260)

Patient Name: [Your Full Legal Name]

Account Number: [Number]

Date of Service: [Date]

Dear Billing Department:

I am writing to formally dispute the above-referenced bill under the No Surprises Act (P.L. 116-260, Division BB, Title I), effective January 1, 2022.

For Surprise Out-of-Network Bills

On [date], I received [emergency services / non-emergency services at an in-network facility] from [provider name], who I have since learned was out-of-network. Under the No Surprises Act, I am protected from balance billing in this circumstance. My cost-sharing obligation must be calculated at the in-network rate, and I cannot be billed for any amount beyond that.

I request that you adjust my bill to reflect only my in-network cost-sharing amount and refund any overpayment.

For Bills Exceeding Good Faith Estimate

I received a Good Faith Estimate of \$[GFE amount] for the services provided on [date]. My final bill of \$[bill amount] exceeds the Good Faith Estimate by \$[difference], which is more than the \$400 threshold established by the No Surprises Act.

I am initiating the Patient-Provider Dispute Resolution (PPDR) process. I understand I have 120 calendar days from the date of this bill to file, and the filing fee is \$25.

I request that you adjust my bill to align with the Good Faith Estimate or provide a written explanation of each charge that caused the difference.

CMS No Surprises Help Desk: 1-800-985-3059

File online at: externalappeal.cms.gov

Sincerely,

[Your Printed Name]

- ❑ **Key Protections:** The No Surprises Act protects you from balance billing for emergency services, non-emergency services from out-of-network providers at in-network facilities, and air ambulance services. For uninsured patients, providers must give a Good Faith Estimate, and if the final bill exceeds it by \$400+ or 100%, you can dispute it through the PPDR process.

Documentation Tracker: Your Paper Trail Is Your Power

Communication Log

Use this table to track every interaction with billing departments, insurance companies, and debt collectors. Document everything – your records are your strongest defense.

Date	Time	Method	Person Spoken To	Department	Phone/Extension	Reference #

Conversation Record

Date	Reference #	Summary of Conversation	Promises Made	Next Steps	Follow-Up Deadline

- Best Practices:** Follow up every phone call with a written summary: "Per our conversation on [date] with [name], you confirmed that..." Send every letter via certified mail with return receipt requested. Never send original documents – always send copies. Save all documents for at least 7 years. Photograph or scan every paper document as backup. If a representative gives their name, write it down immediately – along with title, extension, and employee ID.

Bill Tracking Worksheet

Track the status of each medical bill from receipt through resolution

Use this table to monitor every medical bill you receive. Track original amounts, insurance responses, disputes, appeals, and payments. This worksheet helps you maintain a clear view of your entire medical billing situation.

Bill Overview

Date of Service	Provider Name	Account #	Original Bill Amount	EOB Received? (Y/N)	EOB Patient Responsibility	Bill Matches EOB? (Y/N)

Dispute & Resolution Status

Account #	Itemized Bill Requested (Date)	Errors Found?	Dispute Filed? (Date)	Appeal Filed? (Date/Type)	Charity Care Applied? (Date)	Amount Paid	Remaining Balance	Current Status

Payment & Resolution Tracking

Account Number	Date Applied / Approved	\$0.00	\$0.00	\$0.00	Payment plan details, settlement notes, etc.

Deadline Tracker

Don't miss critical filing windows — track every deadline

Missing a deadline can forfeit your rights. Use this tracker to monitor every time-sensitive action in your medical billing disputes. Set reminders well before each deadline to ensure you have time to prepare and submit your documents.

Internal Insurance Appeal	Account #	MM/DD/YYYY	180 days from denial	Calculate	Pending/Complete/Overdue	Details
External Review			4 months from final denial			
Itemized Bill Response			30 days from request			
Debt Validation Window			30 days from collector notice			
Financial Assistance Application			240 days from first bill			
No Surprises Act PPDR			120 days from bill			

Set Reminders

Add calendar reminders 2 weeks before each deadline to give yourself time to prepare documents and gather supporting materials.

Track Response Times

If you don't receive a response within the legally required timeframe, follow up immediately and document the delay.

Escalate When Needed

If deadlines are missed by providers or insurers, file complaints with state regulators and document all violations.

The Numbers That Give You Leverage

Understanding these statistics gives you confidence and negotiating power

Billing Errors

80%

Bills With Errors

Of medical bills contain at least one error

\$1.3K

Average Error Amount

In errors for bills over \$10,000

32%

Coding-Related Denials

Of claim denials are due to coding errors

Negotiation Success

93%

Get Reductions

Of people who negotiate get bills reduced

\$2.2K

Average Savings

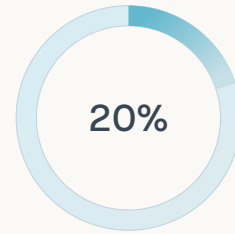
Through negotiation: \$1,500-\$3,000 typical

60%

Professional Results

Savings rate reported by advocates

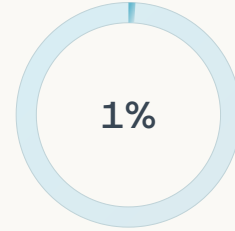
Insurance Appeals



20%

Claims Denied

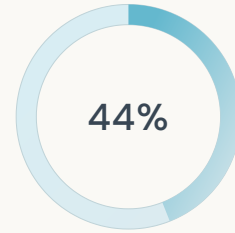
Of all insurance claims are initially denied



1%

Actually Appealed

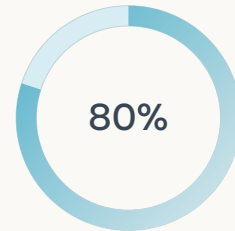
Less than 1% of denials are appealed



44%

Appeals Win

Of internal appeals overturn the denial

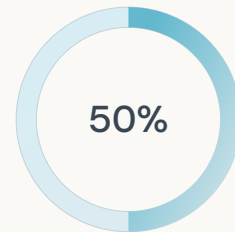


80%

Medicare Advantage

Success rate for Medicare Advantage appeals

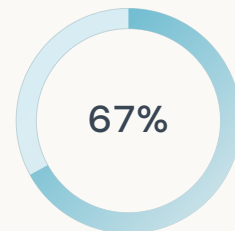
Financial Assistance



50%

Nonprofit Hospitals

Must offer charity care programs



67%

Approval Rate

Of properly prepared applications approved



45%

Free Resources & Tools

Essential websites, databases, and helplines to support your medical billing disputes

Price Comparison Tools

- **FAIR Health Consumer** – fairhealthconsumer.org – See typical charges by CPT code and ZIP code
- **CMS Medicare Fee Schedule** – cms.gov/medicare/physician-fee-schedule/search – What Medicare pays for any service
- **Healthcare Bluebook** – healthcarebluebook.com – Fair price benchmarks
- **CMS Hospital Price Transparency** – cms.gov/hospital-price-transparency – Look up hospital published prices

Financial Assistance

- **Dollar For** – dollarfor.org – Free help with charity care applications (has eliminated \$131M+ in medical debt)
- **Dollar For Hospital Database** – dollarfor.org/hospitals – Check if your hospital is nonprofit

Insurance Appeals

- **CMS External Review** – externalappeal.cms.gov – File a federal external appeal
- **No Surprises Help Desk** – 1-800-985-3059 – Get help with surprise billing disputes
- **Your State Department of Insurance** – Search "[your state] department of insurance complaint"

Legal Resources


- **Consumer Financial Protection Bureau** – consumerfinance.gov – File complaints about debt collectors
- **National Consumer Law Center** – nclc.org – Consumer rights information
- **Patient Advocate Foundation** – patientadvocate.org – Free case management (for qualifying diagnoses)

Medication Prices

- **GoodRx** – goodrx.com – Compare pharmacy prices
- **CMS NADAC** – medicaid.gov/nadac – National average drug acquisition costs

Additional Support

- **CMS No Surprises Help Desk** – 1-800-985-3059 – Federal support for surprise billing issues
- **State Attorney General Consumer Protection** – File complaints about unfair billing practices
- **Local Legal Aid Societies** – Free legal assistance for qualifying individuals

 **Bookmark These Resources:** Save these websites and phone numbers where you can easily access them. When you're in the middle of a billing dispute, having these tools at your fingertips can make the difference between success and frustration. Most of these resources are completely free and supported by federal agencies or nonprofit organizations dedicated to consumer protection.

Your Action Plan: Next Steps

How to get started right now

You now have eight powerful templates and the knowledge to use them effectively. Here's your step-by-step action plan to take control of your medical bills and protect your financial health.

01

Gather Your Documents

Collect all medical bills, EOBs, insurance denial letters, and any correspondence you've received. Organize them by provider and date. Make copies of everything before you begin – never send originals.

03

Request Itemized Bills First

If you don't already have itemized bills with CPT codes, start with Template 1. You cannot effectively dispute or negotiate without seeing the line-by-line breakdown of charges.

05

Take Action Within Deadlines

Use the Deadline Tracker (Card 15) to ensure you don't miss critical filing windows. Set calendar reminders two weeks before each deadline to give yourself preparation time.

07

Send Letters via Certified Mail

Always send dispute letters, appeals, and validation requests via certified mail with return receipt requested. This creates legal proof of delivery and timing.

02

Use the Decision Flowchart

Turn to the flowchart on Card 3 and identify which template matches your situation. You may need multiple templates if you have bills from different providers or at different stages of the dispute process.

04

Audit Every Bill

Use Template 2 to check for the eight most common billing errors. Compare charges against Medicare fee schedules and fair market prices. Mark every questionable charge.

06

Document Everything

Use the Documentation Tracker (Cards 13-14) to log every phone call, letter, and interaction. Your paper trail is your strongest defense and your proof if you need to escalate.

08

Be Persistent and Patient

Resolution can take weeks or months. Follow up regularly, escalate when necessary, and don't give up. You have legal rights – use them.

- Remember:** You are not alone in this process. Millions of Americans face medical billing disputes every year. The difference is that you now have the tools, templates, and knowledge to fight back effectively. These templates have helped countless people reduce or eliminate their medical bills. They can work for you too – but only if you use them.

Understanding Your Rights: Key Federal Protections

The laws that protect you from unfair medical billing practices

Multiple federal laws protect consumers from unfair medical billing, surprise charges, and abusive debt collection. Understanding these protections gives you leverage in every dispute and appeal.



HIPAA Privacy Rule (45 CFR § 164.524)

Guarantees your right to access your complete medical records, including itemized billing statements. Providers must respond to requests within 30 days. This is the foundation of Template 1.



Affordable Care Act (PHS Act § 2719)

Requires health insurers to maintain internal and external appeal processes for claim denials. Insurers must provide clear denial reasons and cannot retaliate for filing appeals. This protects Templates 4A and 4B.



No Surprises Act (P.L. 116-260)

Protects you from surprise out-of-network bills for emergency services and certain non-emergency services at in-network facilities. Requires Good Faith Estimates for uninsured patients. Effective January 1, 2022. This is the basis for Template 8.



Fair Debt Collection Practices Act (15 USC § 1692)

Prohibits abusive, deceptive, and unfair debt collection practices. Requires collectors to validate debts upon request and cease collection activity until validation is provided. This empowers Template 7.



IRS Section 501(r)

Requires nonprofit hospitals to maintain financial assistance policies, widely publicize them, and refrain from extraordinary collection actions for at least 120 days. Hospitals must accept charity care applications for 240 days from the first bill. This mandates Template 6.



Fair Credit Reporting Act (15 USC § 1681)

Regulates how medical debt can be reported to credit bureaus. Medical debts under \$500 cannot be reported, and paid medical collections must be removed from credit reports. As of March 2023, medical debts don't appear on credit reports until they're at least one year old.

State-Level Protections

In addition to federal protections, many states have enacted their own medical billing and debt collection laws. These may include:

- Interest rate caps on medical debt
- Longer statute of limitations for debt validation
- Enhanced charity care requirements
- Mandatory financial counseling before collections
- Restrictions on wage garnishment for medical debt

Contact your state Attorney General's office or Department of Insurance to learn about specific protections in your state.

When to Cite These Laws

Reference specific statutes in your letters to:

- Demonstrate you understand your legal rights
- Put providers and insurers on notice that you are informed
- Create a stronger foundation for any future legal action
- Increase the likelihood of a favorable response

Organizations are far more responsive when they know you understand the laws they're required to follow. The templates in this kit include the specific citations that matter most for each situation.

The System Profits from Confusion. You Now Have Clarity.

What to Do Next

Medical billing in America is designed to be confusing. Complexity is profitable. Hospitals, insurers, and debt collectors rely on information asymmetry – they know the rules, you don't.

This kit eliminates that asymmetry. Every template follows the same logic: identify the problem, cite the law, send the letter, document the result.

You've learned that 80% of medical bills contain errors, but less than 1% of people ever check. You've learned that 20% of insurance claims are denied, but less than 1% are appealed – even though nearly half of appeals succeed. You've learned that 93% of people who negotiate get their bills reduced, saving an average of \$1,500 to \$3,000.

Start Today

Don't wait until bills go to collections. Use Template 1 to request itemized bills immediately for any medical charges you've received.

Don't Pay Without Reviewing

Never pay a medical bill without first auditing it for errors and checking whether you qualify for discounts or financial assistance.

Know Your Deadlines

Use the Deadline Tracker to ensure you file appeals, disputes, and applications within required timeframes.

Document Everything

Your paper trail is your power. Keep detailed records of every interaction, promise, and outcome.

You Are Not Alone

100 million Americans carry medical debt. Millions face unfair billing practices, surprise charges, and wrongful denials every year. But armed with these templates and your legal rights, you can level the playing field.

This kit gives you the same tools that professional patient advocates and attorneys use – except you don't need to pay thousands of dollars for representation. You can do this yourself.

Every template in this kit is based on actual federal law. Every citation is real. Every strategy has worked for real people who refused to accept unfair medical bills.

Structured. Documented. Resolved.

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The Medical Bill Fight Kit – For informational purposes only. Not legal advice.

Final Reminder

This is not legal advice. These templates are educational tools. For complex situations, consult a licensed attorney or certified patient advocate.

But for the vast majority of medical billing disputes, these templates – used properly and persistently – are all you need.

Your next step: Turn to Card 3, follow the flowchart, and start your first template today.