

SAVE UP TO
\$1,300+
on your bills

THE COMPLETE MEDICAL BILL DEFENSE KIT

How to Find Errors, Negotiate Any Bill,
and Dispute Charges You Shouldn't Have Paid

80%

of hospital bills
contain errors

\$1,300

avg overcharge
per patient

93%

negotiate
success rate

Step-by-step scripts, templates & checklists — start saving today

PatientRightsGuide.com

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Introduction

Why Most Americans Leave Thousands on the Table

You received a medical bill. Maybe it came from an emergency room visit, a planned procedure, or a routine appointment that turned into something more. Whatever the source, the number on that bill feels enormous — and the hospital, insurance company, and collections agency are all counting on one thing: that you will pay it without asking a single question.

80% of hospital bills contain at least one billing error	\$1,300 average amount overcharged per patient per visit	93% of patients who negotiate report at least partial success	0.1% of insurance denials are ever formally appealed by patients
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Here is what the medical billing industry does not advertise: **billing errors are not exceptions — they are the standard.** And the financial impact of those errors almost always flows in one direction: away from you and toward the provider.

The good news is that every problem this guide addresses can be challenged, negotiated, or appealed. Most of the time, it requires nothing more than a single phone call and the right words. This guide gives you exactly those words.

What This Guide Will Help You Do

Identify billing errors you are legally entitled to dispute. Negotiate directly with hospital billing using word-for-word phone scripts. Appeal insurance denials using proven letter templates. Apply for charity care programs most hospitals never mention. Execute a clear 30-day action plan so nothing falls through the cracks.

Important Disclaimer

This guide is for educational and informational purposes only and does not constitute legal, financial, or medical advice. For complex legal disputes, consider consulting a patient advocate or healthcare attorney.

1

The 23-Point Hospital Bill Error Checklist

Find the mistakes hospitals are counting on you to miss

Before paying any amount, work through this checklist against your itemized bill. Take 15–20 minutes. Flag every questionable item with a note. You will use those notes when you call using the scripts in Part 2.

First: Always Request Your Itemized Bill

Never dispute from a summary bill. Call billing and say: 'I need a complete itemized statement showing every charge, service code, and billing date for this visit.' They are legally required to provide it. Without it, none of the checks below are possible.

Section A — Identity & Administrative Errors

Simple clerical errors are among the most common — and most costly — mistakes on hospital bills.

- Your full name is spelled correctly on all pages
Misspelled names cause claim rejections billed back to you
- Your date of birth is correct on every page
One wrong digit flags your account as a different patient
- Your insurance ID number matches your card exactly
Top-3 cause of wrongful out-of-pocket charges
- Your provider is listed as in-network for your plan
Out-of-network billing triggers dramatically higher rates
- Admission and discharge dates are both accurate
Wrong dates = wrong number of days = inflated room charges
- Primary vs. secondary insurance is in the correct order
Reversed order causes incorrect coordination of benefits

Section B — Duplicate Charges

Duplicate billing is one of the highest-dollar errors because it doubles or triples legitimate charges. Scan every line for the same service code appearing more than once on the same date.

- Each service/procedure appears only once per day
Identical CPT codes on the same date — common in lab work

- IV bags and basic supplies appear only once per stay
These are frequently charged per hour rather than per use
 - Medications are listed once per dose, not once per pill
'Pill splitting' billing inflates medication costs 2–4x
 - Operating room time is billed as one session for the same surgery
Multiple OR charges for one continuous surgery is an error
 - Anesthesia is billed as a single service unless multiple providers were used
Anesthesia errors are among the largest-dollar billing mistakes
-

Section C — Upcoding & Unbundling




Upcoding bills a more expensive version of a service than what was provided. Unbundling separates package charges that should be billed together. Both increase your cost.

- Room type billed matches the room you actually occupied
Semi-private billed as private = hundreds of dollars per night
 - Level of care matches your actual clinical condition
ICU rates for standard room patients is a known error pattern
 - Wound care is coded for the actual complexity of treatment
Simple bandage changes should not be coded as complex care
 - Physician visit levels match the time the doctor actually spent with you
A 5-minute check-in billed as a Level 4 visit is upcoding
 - Physical therapy sessions match the number you actually received
Cancelled sessions are frequently billed as if they occurred
 - Bundled procedure codes have not been split into multiple charges
Ask your insurer which codes should be bundled under your plan
-

Section D — Non-Covered & Phantom Charges

Phantom charges are services that appear on your bill but were never actually provided. These often result from template billing where staff use a standard charge sheet without removing services that did not apply to your visit.

- Discharge planning fee only present if a social worker met with you
Frequently billed automatically regardless of whether it occurred
- Nursing care fees match actual nursing time in your chart
You can request your medical records to verify this
- Take-home medications are not billed twice if given at discharge
Some hospitals bill inpatient AND at discharge — both for the same item

-  Telephone consultation fees only appear if a physician actually called you
Auto-billed in many systems — frequently a phantom charge
-  All equipment charges reflect items you actually used
Equipment stocked in your room but unused is often billed
-  Any 'observation' fees are noted and you understand their implications
Observation vs. inpatient status has major cost consequences

Found an Error? Here Is What To Do Next

Write down every flagged charge with its line number, service code, and dollar amount. Then use Script #1 in Part 2 to call the billing department. Do not accept verbal corrections — always request a corrected written statement before making any payment.

2

Phone Scripts to Negotiate Any Medical Bill

Word-for-word scripts that cut bills by 30–60% — no experience needed

Billing departments negotiate with patients every single day. The difference between patients who get reductions and those who pay full price almost always comes down to one thing: knowing exactly what to ask for. Use these scripts word-for-word or adapt them to your situation.

Before You Call — Have These 4 Things Ready

1) Your itemized bill with any flagged charges from Part 1. 2) Your insurance Explanation of Benefits (EOB) if you have coverage. 3) A notepad to record the rep's name, date, and result of every call. 4) The total outstanding balance — every script below references this number.

Script #1 — Disputing a Specific Billing Error

Use when you have found a charge that appears incorrect or duplicated. Stay factual — you are asking for clarification, not making accusations.

OPENING

Hi, my name is [YOUR NAME] and I am calling about account number [ACCOUNT NUMBER]. I have reviewed my itemized statement and I would like to clarify a specific charge.

Tip: 'Clarify' is less confrontational than 'dispute' and gets the same result.

IDENTIFYING THE CHARGE

I am looking at line item [LINE NUMBER], a charge of \$[AMOUNT] for [SERVICE NAME] on [DATE]. This service does not appear in my records / appears to be duplicated from [OTHER DATE]. Can you tell me what documentation supports this charge?

Asking for their documentation puts the burden of proof on them.

IF THEY CONFIRM AN ERROR

Thank you. Can you send me a corrected itemized statement in writing within 5 business days? I will hold any payment until I receive the corrected statement.

Never pay before you have the correction in writing.

Script #2 — The Settlement Amount (Most Powerful Script in This Guide)

This script works on correct bills as well as disputed ones. The 'settlement amount' is a discounted payoff figure that most hospitals will offer — but only if you ask directly. It can reduce your balance by 30–70%.

OPENING

Hi, I am calling about account number [ACCOUNT NUMBER]. My current balance is \$[AMOUNT] and I would like to resolve this today. What is the lowest settlement amount your department can accept if I pay in full right now?

Do NOT say 'I cannot afford this.' Say 'I want to resolve this today' instead.

IF THEY OFFER A REDUCTION

Thank you — I can do that. Before I provide payment, can you send a written confirmation of this settlement by email? I want to make sure we are aligned before the payment processes.

Always get the settlement confirmed in writing before paying. This prevents the balance from reappearing.

IF THEY SAY THEY DO NOT DO SETTLEMENTS

I understand. Can I speak with your financial counselor or patient advocate? I want to make sure I have explored every available option before this account impacts my credit.

Mentioning 'patient advocate' and 'credit' together almost always triggers supervisor escalation.

Script #3 — Requesting a Self-Pay Discount + Payment Plan

Many hospitals apply a self-pay discount of 20–40% automatically when asked. Use this when you need to set up installments but want to first lock in a lower balance.

OPENING

Hi, I am calling about account number [ACCOUNT NUMBER]. I want to take care of this balance but the current amount is outside my budget. Before we discuss payment options — am I currently receiving the self-pay discount on this account?

Asking this specific question triggers the discount at most hospitals, even if it was not applied initially.

AFTER CONFIRMING THE ADJUSTED AMOUNT

Thank you. Based on that amount, can we set up a payment plan of \$[MONTHLY AMOUNT] per month with no interest charges? And can you confirm in writing that no collection activity will occur as long as I remain current on payments?

Hospitals almost never charge interest on in-house payment plans. Push back if they suggest otherwise.

Script #4 — Challenging Observation Status

'Observation status' is one of the most expensive billing traps in healthcare. Patients classified as 'outpatient under observation' instead of 'inpatient' may owe dramatically more — even for identical care received over multiple nights.

OPENING

I am calling to confirm my official admission status for my recent stay at your facility from [ADMISSION DATE] to [DISCHARGE DATE]. Was I classified as an inpatient admission or under observation status? I need this confirmed in writing.

Federal law requires hospitals to notify patients of observation status within 36 hours. Request the written notice.

The 3 Power Phrases That Unlock Discounts

1) 'What is the settlement amount?' — Unlocks the discounted payoff option at most hospitals. 2) 'Am I receiving the self-pay discount?' — Triggers 20–40% reduction when asked directly. 3) 'Can I speak with your patient financial counselor?' — Bypasses front-line staff who cannot authorize reductions.

3

Dispute Letter Templates

Use these when phone calls are not enough — or when you need a paper trail

Some disputes require written documentation — because the hospital is unresponsive, because the dollar amount warrants a paper trail, or because you are approaching a legal deadline. These templates are ready to customize and send.

Always Send Via Certified Mail With Return Receipt Requested

Certified mail creates a legal timestamp proving the hospital received your letter. Keep the green receipt card. This matters if the dispute later involves collections or credit reporting.

Letter #1 — General Billing Error Dispute

[YOUR FULL NAME] | [YOUR ADDRESS] | [CITY, STATE, ZIP] | [DATE]

[HOSPITAL NAME] Attn: Billing Department [HOSPITAL ADDRESS]

Re: Billing Dispute — Account Number: [ACCOUNT NUMBER]

Dear Billing Department, I am writing to formally dispute charges on account number [ACCOUNT NUMBER] for services rendered on [DATE OF SERVICE]. After reviewing my itemized statement, I have identified the following charges that I believe are incorrect, duplicated, or not supported by the services I actually received: Charge 1: [DESCRIPTION] | Code: [CPT CODE] | Amount: \$[X] | Reason: [REASON] Charge 2: [DESCRIPTION] | Code: [CPT CODE] | Amount: \$[X] | Reason: [REASON] I request the following within 30 days: 1. A written explanation for each disputed charge with supporting documentation 2. A corrected itemized statement reflecting any adjustments 3. Written confirmation that no collections activity will begin while this dispute is pending Please contact me at [PHONE] or [EMAIL]. I am committed to resolving this promptly once I have received an accurate statement. Sincerely, [YOUR SIGNATURE] [YOUR PRINTED NAME]

Letter #2 — No Surprises Act Dispute

Use this letter if your final bill exceeded your pre-service Good Faith Estimate by more than \$400. The No Surprises Act gives you 120 days from the bill date to dispute. Missing this deadline waives your federal right to challenge the excess charge.

[YOUR FULL NAME] | [ADDRESS] | [DATE]

Re: No Surprises Act — Good Faith Estimate Dispute Account Number: [ACCOUNT NUMBER]

Dear Billing Department, Pursuant to the No Surprises Act (Public Law 116-260), I am formally disputing my bill for services rendered on [DATE OF SERVICE]. Prior to my visit, I received a Good Faith Estimate indicating an expected cost of \$[GFE AMOUNT]. My final bill totals \$[ACTUAL AMOUNT], which exceeds the estimate by \$[DIFFERENCE] — more than the \$400 federal threshold. I request that this bill be adjusted to fall within \$400 of the original Good Faith Estimate, or that the federal dispute resolution process be initiated as outlined in 45 CFR Part 149. Please respond in writing within 30 days. No payment will be submitted until this matter is resolved. Sincerely, [YOUR SIGNATURE] | [YOUR NAME] | [PHONE] | [EMAIL]

4

Insurance Denial Appeal Kit

Only 0.1% of denials are ever appealed — most appeals succeed

When your insurance company denies a claim, most patients accept it as final. They should not. Internal appeals succeed at a meaningful rate — and if the internal appeal fails, you have additional federal and state options that cost nothing to pursue.

The 4 Most Common Denials — and How to Fight Each One

Denial Type	What It Means	Your Best Response
Medical Necessity	Insurer claims service was not medically necessary	Request the specific criteria used. Get your doctor to write a letter of medical necessity.
Out-of-Network	Provider was not in your plan network	Request a network exception — especially if no in-network provider was reasonably available.
Prior Authorization	Service required pre-approval that was not obtained	If ordered urgently, appeal with clinical notes documenting why pre-auth was not feasible.
Experimental/Investigational	Insurer claims treatment is unproven	Request a peer-to-peer review between your doctor and the insurer's medical reviewer.

The 4-Step Appeal Process

Step 1 — Get the Denial in Writing

Call your insurer and request the denial reason, the specific policy language, and the name of the reviewing clinician. You typically have 180 days from the denial notice to file an internal appeal.

Step 2 — File Your Internal Appeal

Write a formal appeal letter (template below) citing the denial code, your policy number, and supporting documentation from your doctor. Send via certified mail.

Step 3 — Request External Review

Under the ACA, if your internal appeal fails, you have the right to a free independent external review. File within 4 months of the internal denial. The decision is binding on the insurer.

Step 4 — File a State Insurance Complaint

File with your state's Department of Insurance at no cost. This frequently causes the insurer to reopen your case to avoid a formal complaint record.

Insurance Denial Appeal Letter Template

[YOUR NAME] | [ADDRESS] | [DATE]

[INSURANCE COMPANY] | Attn: Appeals Department | [ADDRESS]

Re: Appeal of Claim Denial | Claim #: [CLAIM #] | Policy #: [POLICY #] | Member ID: [ID]

Dear Appeals Department, I am formally appealing the denial of claim [CLAIM NUMBER] dated [DENIAL DATE] for [SERVICE DESCRIPTION] provided by [PROVIDER] on [DATE OF SERVICE]. The stated denial reason is: '[EXACT DENIAL REASON].' I am appealing for the following reasons: 1. [Reason — e.g., 'This service was medically necessary per attached letter from Dr. [NAME].'] 2. [Reason — e.g., 'This service is covered under Section [X] of my policy, which states: [POLICY LANGUAGE].'] 3. [Reason — e.g., 'Published clinical guidelines support this treatment for my documented condition.'] Enclosed documentation: - Letter of medical necessity from Dr. [NAME] dated [DATE] - Relevant medical records from [DATE RANGE] - Applicable clinical guidelines I request a full written decision within the timeframe required by my state's regulations. If this appeal is denied, I will exercise my right to independent external review. Sincerely, [YOUR NAME] | [PHONE] | [EMAIL]

5

Charity Care & Financial Assistance Guide

Free and reduced-cost programs most hospitals will never mention to you

Every non-profit hospital in the United States is legally required to offer financial assistance to qualifying patients. These programs — called charity care or Financial Assistance Programs (FAP) — can reduce your bill by 50%, 80%, or 100%. Income limits are often far higher than patients expect.

What Hospitals Are Required to Do (and Rarely Volunteer)

Non-profit hospitals receive tax exemptions in exchange for providing charity care. They must have a written Financial Assistance Policy, post it publicly, and apply it to eligible patients. If no one has mentioned this, ask directly: 'Does your hospital have a Financial Assistance Policy and may I apply?'

Federal Poverty Level Reference Table (2024)

Most hospital FAPs use FPL as their benchmark. Many programs extend to 300–400% FPL.

Family Size	100% FPL	200% FPL	300% FPL	400% FPL
1 person	\$15,060	\$30,120	\$45,180	\$60,240
2 people	\$20,440	\$40,880	\$61,320	\$81,760
3 people	\$25,820	\$51,640	\$77,460	\$103,280
4 people	\$31,200	\$62,400	\$93,600	\$124,800
5 people	\$36,580	\$73,160	\$109,740	\$146,320

The Charity Care Application Script

CALL THE FINANCIAL COUNSELOR — NOT BILLING

Hi, I recently received a bill for services at your facility and I would like to apply for your Financial Assistance Program. Can you connect me with your financial counselor or patient advocate?

Ask specifically for 'financial counselor' or 'patient advocate' — not the billing department.

WHEN THEY ASK ABOUT YOUR INCOME

I want to complete the application correctly. Can you tell me the required documentation and the income thresholds for your program? Also — does my bill go on hold while my application is being reviewed?

Most hospitals pause all collection activity while a charity care application is pending.

Additional Programs to Ask About

Sliding Scale Discounts

Many hospitals offer tiered discounts based on income, even for patients who don't qualify for full charity care. Ask: 'Do you offer a sliding scale discount based on income?'

Self-Pay Rate

Patients without insurance — or who choose to pay out of pocket — often receive 20–50% off automatically. Ask: 'What is the self-pay rate for this account?'

State & County Programs

Many states have supplemental assistance for residents who don't qualify for Medicaid. Search '[YOUR STATE] hospital financial assistance program' to find current options.

Community Health Centers

Federally Qualified Health Centers charge on a sliding income scale for future care. Visit findahealthcenter.hrsa.gov to locate one near you.

6

Your 30-Day Action Plan

A clear day-by-day roadmap to resolve your medical bill starting today

The biggest mistake patients make is not taking action — either because the process feels overwhelming or because they assume nothing will change. This plan breaks everything into specific, manageable steps you can execute one at a time.

Timeline	Action	What to Do
Days 1–3	Gather all documents	Request your itemized bill. Collect your insurance EOB. Gather pay stubs for a potential charity care application.
Days 4–7	Complete the audit	Work through the Part 1 checklist. Flag every questionable charge with the line number and dollar amount.
Days 8–10	Make your first call	Use Script #1 or #2 from Part 2. Write down the rep's name, date, and exact outcome of the call.
Days 11–14	Follow up in writing	If the call did not resolve the issue, send Dispute Letter #1 via certified mail. Keep your copy.
Days 15–18	Apply for financial assistance	Call the financial counselor and apply for the FAP using the Part 5 script.
Days 19–22	File your insurance appeal	Submit the Part 4 appeal letter with all supporting documentation. Note your external review deadline.
Days 23–27	Escalate if needed	If the hospital is unresponsive, file with your state Dept. of Insurance or AG's Consumer Protection office.
Days 28–30	Finalize & document	Get written confirmation of any settlement, reduced balance, or payment plan. Keep all records for 7 years.

If Your Account Goes to Collections

Even after a bill goes to collections, you have rights. The Fair Debt Collection Practices Act gives you 30 days to request written debt verification after first contact. Once you send a written dispute, the collector must stop all activity until they provide verification. Use the same dispute letter framework from Part 3, addressed to the collection agency.



Quick Reference: Rights, Deadlines & Resources

The most important numbers, laws, and contacts in one place

Key Legal Deadlines

Deadline	What It Covers
180 days	Standard window to file an internal insurance appeal after a denial notice
120 days	No Surprises Act window to dispute a bill exceeding your Good Faith Estimate by \$400+
30 days	Window to send written debt validation request after first contact from a collector
4 months	Typical deadline to file for external review after an internal appeal is denied
7 years	Recommended retention period for all medical billing documentation and correspondence

Key Federal Protections

No Surprises Act (2022)

Protects against unexpected out-of-network bills for emergency care and certain scheduled services. Requires Good Faith Estimates before treatment. Provides a dispute process for bills exceeding estimates by \$400+.

ACA — Internal Appeals & External Review

Gives you the right to appeal any insurance denial internally and, if that fails, to request a free independent external review by a third party. The external review decision is binding on the insurer.

Fair Debt Collection Practices Act (FDCPA)

Prohibits abusive or deceptive debt collection. Gives you the right to request debt validation within 30 days of first contact. Collectors may not call before 8 a.m. or after 9 p.m.

HIPAA — Right to Access Records

You have the right to receive a complete copy of your medical records within 30 days at minimal cost. This is essential for verifying that billed services actually occurred.

Free Resources & Where to File Complaints

Resource	Website / Contact	What They Help With
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CMS (Medicare/Medicaid)	cms.gov	Federal billing rules, No Surprises Act disputes
State Insurance Dept.	naic.org/state-map	File complaints against insurance denials
CFPB	cfpb.gov	Medical debt collection complaints
Patient Advocate Foundation	patientadvocate.org	Free case management for complex cases
HRSA Health Center Finder	findahealthcenter.hrsa.gov	Sliding-scale community health centers
Healthcare Bluebook	healthcarebluebook.com	Check fair prices for procedures in your area
NeedyMeds	needymeds.org	Prescription drug assistance programs

You Have More Power Than You Think

Hospitals negotiate bills every day. Insurance companies expect a percentage of denials to be appealed — and reversed. Charity care programs exist specifically for patients in your position. The only thing standing between you and a significantly lower bill is knowing what to ask for. Now you do. Start with one step. Make one call. Send one letter. The results are often faster — and larger — than most patients ever expect.