Refund Request Letter
(To an insurer that has requested money back)

Attention: Claims Manager
Payer- name and address

RE:
Patient:
Policy:
Insured:
Treatment Dates:
Amount requested:

Dear Claims Manager:

We have received notification from your company regarding a refund for the claim referenced above.
In accordance with our policy on refund requests, and in light of the fact that our books are closed on this case, we will not be issuing any refund. We have conducted an internal review of this claim and after such review we find no discrepancy regarding claim payment and contractual adjustments.

Further, courts have generally ruled that insurance companies may not be entitled to refund payments that result from a mistake made by the insurer. Contrariwise, legal statutes stipulate that healthcare providers are innocent parties and that the party who created the loss must incur it.

Our services have been provided to the patient in good faith and payments that have been received have been exhausted. A reimbursement of insurance benefits would compromise our ability to recoup payment from the patient has time limits to pursue other avenues have now expired.

We might consider such a refund request upon receipt of the following:
- Copies of the plan terms and policy
- Proof of patient cooperation in this matter so that we may bill the patient
- The specific date and time the error was discovered and by whom

Lastly, any deduction or offsets of the supposed overpayment from future reimbursement checks may cause us to pursue legal recourse on this matter. Our view is that we have been properly reimbursed for services provided and the claim is now closed in this matter.

Sincerely,
Signature line
Dear Patient,

My name is ____________. I am the Patient Finance Counselor for _______________ clinic. I am sending this letter because I have GREAT NEWS for those patients that are sincere and willing to clear up their past due accounts!

If you contact me or my staff within the next 10 days I may be able to discount your balance as much as 20%! We offer many Easy Pay options that will make paying your balance simple and affordable.

By responding to the offer to pay your balance you will be able to:
  - Save as much as 5 to 20% off your balance.
  - Be able schedule future services
  - Avoid unnecessary collection problems and maintain your relationship with our clinic.

I want to thank you for your allowing us to provide your care and your cooperation on this delicate matter. I look forward to hearing from you soon.

Sincerely,

PS- If you do not respond to this offer, I must assume that you are not willing to make good on your obligation and we will be forced to take further collection action. Please contact our office to avoid potential collection problems that could ruin your credit. Thank you!

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Positive Past Due/old balance

Dear Patient,

In the past year (your office) has upgraded its computer and billing systems in an effort continue to provide outstanding and efficient service for our clients.

In doing so we have discovered that you have a past due balance in the amount of $_________. The date of the last statement was __________ for $ __________.

By law, it may be considered fraud for us to collect from some patients & not others. We must attempt to collect full balances from all patients due to Federal compliance rules.

The good news is we have many Easy Pay options that can make paying your balance simple and affordable. If you can pay your balance in full you may receive a 10% discount. If you need to make monthly payments, and can pay using Easy pay, you may qualify for a discount on your bill. Our patient finance counselors will be more than happy to explain our new paperless billing through Easy Pay.

As long as you contact us within 10 days of this letter we will be able to place a HOLD on your account and no negative action will be taken.

Thank you for entrusting us with your healthcare needs. We look forward to serving you and your family for many years to come.

Sincerely,
Patient won’t provide Necessary Information to Insurance Company

Dear Patient,
We have received correspondence from [name of carrier] stating that they have requested additional information from you on the matter of your insurance claim. AS of this notice they have not received that important documentation necessary to process your claim.

Until they receive it, they will not remit payment for services rendered to you by [provider] on [date]. Therefore, the responsibilities of the charges incurred are due by you.

Thank you for your prompt attention to this matter. Our patient finance counselor(s) will be more than happy to assist you in taking care of this balance.

{closing text}

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Won’t remit insurance check

Patient

Dear Patient,
We have received notification from your insurer that you are in possession of a check in the amount of [$______.00] that belongs to our office for services rendered. In light of the fact that you have authorized this office to receive payment from your insurance company, we ask that you forward that payment immediately.

If we do not receive payment in 7 days, we will be forced to report this “income” to the IRS (Internal Revenue Service). IRS code states that such payments are considered income and must be reported on federal returns. Further, you still have an outstanding balance for which this payment was designated, so this balance will be sent to collection immediately if again, payment is not received within 7 days.

We provided service in good faith to you and ask that you respond in kind.

{Closing text}
  - Enclose verification of their SS# and an IRS 1099 form with this letter (you can find the form on www.irs.gov)
Dear Claims Manager:

Refusing to process a claim due solely to the lack of timely filing may be a violation of many states courts rulings on the matter. On [date], we received notification that this claim was not (or will not be) considered for payment because of lack of timely filing.

Please see Ostrager & Newman’s Handbook (9th Edition) regarding insurance Coverage Disputes. You will find case law that finds insurers may be prejudiced by their ability to file early settlements, discuss policy provisions, and make proper investigations. However, we do not in any way believe that your company was put at a disadvantage by any late filing or was prejudiced in any way.

In addition, your company was provided all necessary claim information and relevant documentation in a timely manner. We have enclosed a copy of the certified receipt from USPS, copies of the faxed transmissions, claims filed electronically with status reports showing dates and times of claim receipts, etc.

Therefore, we fully expect and would appreciate immediate processing if this claim. Thank you for your prompt attention to this matter.

[office managers signature]
Medical Necessity Letter

Today’s date

[Attention: Claims Manager]
[Insurance company address]

Re: Patient
Policy #
Insured:
Treatment Date:
Amount:

Dear Claims Manager:

Based on your determination that care was not “medically necessary”, you have denied benefits for this claim.

However, nowhere in the EOB were we able to determine the validity of this decision. In light of this fact, and, in order to support your denial of benefits, we ask that you provide the following information to both our office and the patient.

Please provide us with a description of any and all records, documents, and related materials that were reviewed by your company, as well as the name and credentials of the person or persons who interpreted the treatment plan documentation. In addition, we also ask that you provide us evidence of any expert medical opinions that justify your determination for lack of medical necessity for this treatment.

Since we were given a pre-certification number for this service as pre-approved, and now you are saying it is not being reimbursed, we will be transferring this balance to the patient for payment.

After we receive this information, and discuss this with the patient and their employer who has contracted you as their carrier for their employees, we will notify you of our disposition in this matter.

Sincerely,

[Suzie Billing manager]
Modifier –22 Letter

Insurance Company

1234 Anyway street
Anytown, USA

Re: Patient
Attached Claim

Dear Insurance Company rep:

Please find enclosed a copy of our claim dated ______________. We were paid our contract rate of $______________. After further internal review, we have determined that this claim was an “increased procedural service”. (AMA CPT 2016).

This procedure was scheduled for ________ hours, but actually took ___________ hours. The technical difficulty of this procedure was such that it required increased intensity, time and increased mental effort on behalf of the physician.

The attached report outlines these issues in the highlighted section. I have also included the 2016 CPT Book copy of the Appendix A, Modifier’s section to describe the 22 modifier in this circumstance.

We are respectfully requesting additional reimbursement of $_____, to reflect the more appropriate reimbursement for this service.

Please let us know if you have any questions. We look forward to hearing from you and receiving additional payment as requested.

Thank you for your consideration in the matter.

Sincerely,

Nicole Business Manager

Cc: attached
    CPT 2016 –22 modifier section
    CPT Cover
    CPT X instructions for use
To Patient Appeals Letter

Dear _____________________

Enclosed is a copy of the appeal we have submitted on your behalf to your insurance carrier. We are respectfully asking the carrier to review their reimbursement decision based on the additional information and proof of medical necessity that we are providing.

We are informing you of our action for a number of reasons. One, we hope to arm you with the necessary information needed for you to contact your carrier as well and plead your own case. Insurance carriers are often more receptive listening to the insured rather than the provider. Second, we want you to know we have extended our efforts beyond the norm in attempting to seek reimbursement and payment from your insurance carrier.

Finally, despite our combined efforts, an appeal is not a guarantee of additional reimbursement. The insurance carrier, based on the specifics of your particular plan, has the final word. Should the appeal fail, responsibility of payment may be transferred to you.

Any concerns, please give me a call. I serve as your accounts resolution representative at the ______________________ billing center.

Sincerely,
Mary Jo Biller/Coder
A. Notifier:  
B. Patient Name:  
C. Identification Number:  

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn’t pay for D. __________ below, you may have to pay.  
Medicare does not pay for everything, even some care that you or your healthcare provider have  
good reason to think you need. We expect Medicare may not pay for the D. __________ below.

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<th>D.</th>
<th>E. Reason Medicare May Not Pay:</th>
<th>F. Estimated Cost</th>
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WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. __________ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance  
that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the D. __________ listed above. You may ask to be paid now, but I  
also want Medicare billed for an official decision on payment, which is sent to me on a Medicare  
Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for  
payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare  
does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ OPTION 2. I want the D. __________ listed above, but do not bill Medicare. You may  
ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ OPTION 3. I don’t want the D. __________ listed above. I understand with this choice I  
am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on  
this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).  
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:  
J. Date:  

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security  
Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850

Form CMS-R-131 (03/11)  
Form Approved OMB No. 0938-0566

Modifiers: -GA and/or -GX