INSERT NAME

INSERT FULL ADDRESS HERE

INSERT PHONE # HERE

INSERT DATE SENT

 Re: **Request for Medical Bills**

 Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_xxx-xx-­­\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Sir or Madam:

I was a patient of your facility.

I am requesting a detailed statement of all charges incurred from \_\_\_\_\_\_\_\_\_\_\_ to present at your facility.

Please be sure the detailed itemized statement reflects all entities with whom charges were filed (e.g. Medicare, Medicaid, private insurance, etc.) and all payments received for those charges.

Please send these records to my attorneys at:

Frith Ellerman & Davis Law Firm, P.C.

P.O. Box 8248

Roanoke, Virginia 24014

Facsimile (540)985-9198

You may contact my attorneys at (540)985-0098 if you have any questions about this request.

Respectfully,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_