Patient Initiated Complaint Form

Practice Name________________________________ Date_________________

Address_____________________________________

City, State, Zip_______________________________

Phone________________________________

We filed the attached claim form with the _____________________________ Insurance Company on ___________________________. It has not been paid or denied.

Benefits were assigned to ________________________________ and, as of today's date, payment has not been received. I am responsible for payment of this bill.

Please accept this letter as a formal written complaint against the _________________________ Insurance Company.

Patient's Name____
Patient's Signature______________________________________