Request for Itemized Medical Bill

[Your name]

[Your address]

[Date]

[Name of care provider or facility]

[Address]

RE: [Your medical identification number or other identifier used]

Dear [Provider],

I [my parent/child] was a patient at your facility from [start date] to [end date]. I [we] received a summary bill for services provided. I [we] would like to request a detailed itemized medical bill for review. I understand that I [we] am [are] entitled to a copy of the detailed bill at no charge. Please forward the bill to the above address.

If you have any questions you may contact me at [phone number] or [email].

Sincerely,

[Patient signature]

Your Name

CC: File

Note: If someone other than the patient is requesting medical records please enclose the documentation which shows you are authorized to act for the patient. A HIPAA compliant authorization signed by the patient or a Power of Attorney giving rights to someone designated by the patient. Check the hospital or other provider's website to see if an Authorization form is provided. If not you may find a template form by searching "HIPAA authorization for medical record."