



Patient Initiated Complaint

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Date: _____

The attached claim was filed with _____ on _____. It has not been paid or denied to date.

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

This letter serves as a formal written complaint against _____. This letter also serves as notification of my intent file a formal complaint with the Insurance Commissioners if this matter is not resolved immediately.

Signature _____