

Date

**VIA U.S. CERTIFIED/REGISTERED MAIL  
RETURN RECEIPT REQUESTED**

**Our Patient:  
Non-Payment:  
Your Insured:  
Claim Number:  
Overdue:**

**Reason for  
DOA:  
Amount**

**Date(s) of Service:**

Dear Mr./Ms.

This letter will serve as our **“DEMAND LETTER under s. 627.736(11).”** Pursuant to Florida Statutes we are hereby giving formal written notice of our intent to initiate litigation against your company.

The following checked off documents have been enclosed for your assistance:

Health Care Finance Administration 1500 form;

UB 92 form;

Itemized statement specifying:

1. The name of the medical provider who rendered the treatment, service,

accommodation or supplies that forms the basis of such claim;

2. The exact amount of the charges;
3. The date(s) of treatment, service or accommodation; and
4. The type of benefit claimed to be due;



Insurance Explanation of Benefits (EOB) form.

If you decide to pay the overdue amount within seven (7) business days after receipt of this notice, said payment should include statutory interest and a penalty of 10% of the overdue amount, subject to a maximum penalty of \$250. In addition we request payment of a postal charges in the amount of \$\_\_\_\_\_ pursuant to F.S. §627.736(11)(c).

Thank you for your anticipated cooperation.