

Your Letterhead

Date of Letter

Attorney Name
Address
City State Zip

In re: Patient Name, Date of Accident
Lien on settlement of case

Dear Attorney Lastname;

As you are aware, Mr. Patient Name presented to our office on <date> for treatment of injuries sustain in an automobile accident on <date of injury>.

Our clinic policy requires us to submit to the patient's automobile insurance for reimbursement of medically necessary care. If the medical portion of the auto policy is exhausted, we bill any health insurance the patient has. In this case the (patient had no auto insurance) (the patient had exhausted their benefits) and our understanding is that Mr. Patient Name has retained you to represent him in recovering costs associated with the above accident.

Our standard procedure is to request that the patient sign a lien with our office (copy provided) directing that our office be paid from the settlement. Our understanding is that you have refused to honor the properly executed lien by the patient and have instructed the patient to submit the treatment our office is providing to his health insurance.

We wanted to make you aware of the limitations on this patient's policy.

(The patient has Title 19 Medicaid. Under Wisconsin laws, Medicaid will only cover a minimal exam, two x-rays, and 20 spinal adjustments. The treating physician feels that Mr. Patient Name needs a more comprehensive exam to document and substantiate injuries received, additional radiographic films, and modalities consisting of therapeutic exercise, intersegmental traction, and electric muscle stimulation. The total per visit, not covered by Medicaid, will be an average of \$89 per visit. As Medicaid does not cover these services, and as you are unwilling to provide a letter of protection, and as allowed by Medicaid with advanced notification, Mr. Patient Name will be responsible for the additional charges each visit.)

(The patient has a managed care plan through ACN under United Health Care. Our experience is that ACN will only cover a minimal exam, two x-rays, and between 8-12 spinal adjustments. The treating physician feels that Mr. Patient Name needs a more comprehensive exam to document and substantiate injuries received, additional radiographic films, and modalities consisting of therapeutic exercise, intersegmental traction, and electric muscle stimulation. The total per visit,

not covered by ACN, will be an average of \$89 per visit. This would be in addition to the deductible of \$500 and a per visit co-pay of \$45. As ACN does not cover these services, and as you are unwilling to provide a letter of protection, and as allowed by our provider agreement with ACN with advanced notification, Mr. Patient Name will be responsible for the additional charges each visit.)

All other attorneys we have worked with in our <ten> years of practicing here have not had a problem with signing a letter of protection in exchange for our agreeing to await settlement. We are not clear on your refusal.

Please indicate as soon as possible, preferable by return call to our office manager, Manager's Name, or to the treating physician, Doctor's Name whether you would prefer:

- a) We bill the patient's health policy and charge the patient each visit for services not covered, (estimated patient out of pocket approximately \$2,400) or
- b) You are directing the physician to only provide those services as covered under Mr. Patient Name's existing health insurance plan, or
- c) If you are willing to provide a letter of protection or honor our physician's lien as executed by our patient/your client.

We need your answer on the above as soon as possible so we know how to proceed on this case. You seem to have a specific idea on how you want our office to handle this and would like you guidance on how you would like us to proceed before our patient incurs a large balance.

Sincerely,

Doctor Name

Cc: Patient Name
Address
City, State, Zip