Explanation of Benefits

Date: [Insert Date]
Member Name: [Member Full Name]
Member ID: [Member Identification Number]
Group Number: [Group Number]
Claim Number: [Claim Number]
Provider Name: [Provider Name]

Service Details

Service Date	Description	Amount Billed	Allowed Amount	Not Covered	Plan Paid	You Owe
[MM/DD/YYYY]	[Service Description]	[Billed Amount]	[Allowed Amount]	[Not Covered Amount]	[Paid by Plan]	[Your Responsibility]

Claim Summary

Total Amount Billed: [Total Amount Billed]
Total Plan Paid: [Total Plan Paid]
Total You Owe: [Total You Owe]

Notes & Additional Information

[Include any remarks, denial reasons, or next steps if applicable.]

If you have questions about this Explanation of Benefits, please contact our customer service at [Phone Number] or visit [Website].

Sincerely,
[Health Insurance Company Name]