

MEDICAL BILL AUDIT

What we found on your bill.

Prepared for you · May 27, 2026

\$12,900

of potential savings flagged

on a \$30,000 bill
Anytown Regional Medical Center
(illustrative) — Anytown, NY

\$30,000
TOTAL BILLED

\$17,100
BENCHMARK ESTIMATE

8/10
SEVERITY

SUMMARY

ILLUSTRATIVE SAMPLE — not a real patient's bill or a real hospital. This audit reviews a \$30,000 bill from a two-night cardiac stay. Across 13 line items, 8 charges totaling \$12,900 are flagged for your review against six federal data sources. The largest concerns are status billing (an inpatient room rate where the chart documents observation), an emergency visit coded above the documented acuity, and supply and drug charges well above federal benchmarks. Flagged amounts are charges worth questioning, not guaranteed savings — the hospital decides what, if anything, to adjust.

SEVERITY ASSESSMENT

High — multiple material issues

Informational analysis. Self-help software — not a substitute for a credentialed medical billing advocate, attorney, or CPA. Not legal, medical, or billing advice. Review and customize every flagged item and every dispute letter for your specific situation before acting.

Line-item analysis

Each charge on the bill, cross-referenced against six federal data sources. Flagged rows had a specific issue identified.

FACILITY

Anytown Regional Medical Center (illustrative)
Anytown, NY

STATUS

501(c)(3) non-profit · §501(r) eligible

DESCRIPTION	CPT	BILLED	BENCHMARK	SAVINGS
Room and board, 2 nights (inpatient rate) The medical record documents observation status, which bills at a lower rate than an inpatient admission.	—	\$9,400	\$4,200	\$5,200
Emergency department visit, level 5 (highest acuity) Stable vitals on arrival; the documented presentation appears to support level 3 (CPT 99283), a lower-acuity code.	99285	\$3,100	\$700	\$2,400
Surgical supply kit Priced well above the hospital's own published price-transparency rate for the same kit.	—	\$2,150	\$350	\$1,800
Comprehensive metabolic panel, billed alongside its component tests CMS bundling rules (NCCI) treat the panel and its components as a single billable unit; billing both double-counts.	80053	\$840	\$140	\$700

IV saline and a common medication	—	\$620	\$60	\$560
<p>Priced far above the federal drug-acquisition cost (NADAC), which prices a liter of saline at a few dollars.</p>				
Complete blood count (billed twice on the same day)	85025	\$240	\$10	\$230
<p>One charge appears to duplicate the other on the same date of service.</p>				
CT scan, head, no contrast (global rate)	70450	\$1,400	\$390	\$1,010
<p>Billed at the global rate, which bundles the scan and the radiologist's read; only the technical component appears to have been provided here.</p>				
Duplicate medication and supply lines	—	\$1,200	\$200	\$1,000
<p>The same items appear billed more than once.</p>				
Cardiac monitoring / telemetry, 2 days	—	\$4,200	\$4,200	—
Inpatient physician care (cardiology)	99223	\$2,800	\$2,800	—
EKG and cardiac enzyme tests	—	\$1,650	\$1,650	—
Pharmacy — routine medications	—	\$1,400	\$1,400	—
Chest X-ray, single view	71045	\$1,000	\$1,000	—

What we flagged for review

Issues identified by the audit. Review each before submitting disputes — these are patterns we screen for, not legal conclusions.

- Room billed at the inpatient rate where the chart documents observation status.
- Emergency visit coded at level 5; documentation appears to support level 3.
- Surgical supply kit priced well above the hospital's own published rate.
- Comprehensive metabolic panel billed alongside its component tests (bundling).
- IV saline and a medication priced far above federal acquisition cost.
- Complete blood count billed twice on the same day.
- CT scan billed at the global rate when only the technical component was provided.
- Two additional apparent duplicate medication and supply lines.

Financial-assistance programs you may qualify for

Apply directly with the facility or program. Review eligibility criteria carefully before submitting.

§501(r) financial assistance (charity care)

WHAT IT COVERS

Anytown Regional is illustratively a non-profit hospital. Federal law requires non-profit hospitals to publish a Financial Assistance Policy and offer discounted or free care to patients below an income threshold.

ELIGIBILITY

Commonly households below roughly 200–400% of the Federal Poverty Level. Check the hospital's Financial Assistance Policy for the exact threshold and how to apply.

LINE-ITEM DISPUTE**Line-by-line dispute letter**

The next page is the letter itself — unbranded and ready to print and mail. Read this page first to know what this letter does, when to send it, and what to fill in.

PURPOSE

Disputes the flagged charges, naming the code, the benchmark, and the math for each.

WHEN TO SEND

After you have the itemized bill in hand.

HOW TO SEND

Certified mail, return receipt requested.

BEFORE YOU PRINT

Replace every [BRACKETED PLACEHOLDER] with your specific details: your name, your address, the account number printed on the bill, the date of service, and the hospital's billing-department mailing address. Add the date you mail the letter.

AFTER YOU PRINT

Sign by hand in blue or black ink. Mail by certified mail with return receipt — that creates a record of delivery and starts the 30-day clock most statutes give the provider to respond. Keep a photocopy of the signed letter for your records.

This letter is a starting point, not legal advice. Your specific situation may warrant additional details — review every line before sending.

[Sample preview — letter body withheld] Your full audit includes the drafted dispute letter for each flagged charge on your bill, with the code, the benchmark math, and the federal statute that puts a 30-day clock on a written response. You add your signature, mail it certified, and keep every dollar of any reduction.

ITEMIZED STATEMENT REQUEST**HIPAA §164.524 itemized-statement request**

The next page is the letter itself — unbranded and ready to print and mail. Read this page first to know what this letter does, when to send it, and what to fill in.

PURPOSE

Requests the full line-by-line bill if you only received a summary.

WHEN TO SEND

First, if your bill shows only department totals.

HOW TO SEND

Certified mail, return receipt requested.

BEFORE YOU PRINT

Replace every [BRACKETED PLACEHOLDER] with your specific details: your name, your address, the account number printed on the bill, the date of service, and the hospital's billing-department mailing address. Add the date you mail the letter.

AFTER YOU PRINT

Sign by hand in blue or black ink. Mail by certified mail with return receipt — that creates a record of delivery and starts the 30-day clock most statutes give the provider to respond. Keep a photocopy of the signed letter for your records.

This letter is a starting point, not legal advice. Your specific situation may warrant additional details — review every line before sending.

[Sample preview — letter body withheld] Your full audit includes the drafted HIPAA §164.524 request letter, citing 45 CFR §164.524 and asking the hospital to send a complete itemized statement within 30 days. (Or use our free standalone tool at medibillsaver.com/itemized-bill-request whenever you need this letter on its own.)

CHARITY CARE APPLICATION

Charity-care request (§501(r))

The next page is the letter itself — unbranded and ready to print and mail. Read this page first to know what this letter does, when to send it, and what to fill in.

PURPOSE

Asks a non-profit hospital to apply its financial-assistance policy.

WHEN TO SEND

If you may qualify under the income threshold.

HOW TO SEND

With the hospital's Financial Assistance Application.

BEFORE YOU PRINT

Replace every [BRACKETED PLACEHOLDER] with your specific details: your name, your address, the account number printed on the bill, the date of service, and the hospital's billing-department mailing address. Add the date you mail the letter.

AFTER YOU PRINT

Sign by hand in blue or black ink. Mail by certified mail with return receipt — that creates a record of delivery and starts the 30-day clock most statutes give the provider to respond. Keep a photocopy of the signed letter for your records.

This letter is a starting point, not legal advice. Your specific situation may warrant additional details — review every line before sending.

[Sample preview — letter body withheld] Your full audit includes the drafted §501(r) charity-care request letter for non-profit hospitals, asking the financial-assistance office to apply the hospital's policy and pause collection activity while you're reviewed.

About this report

What we did, where the numbers come from, and what to do if you need more.

METHOD

Every line item on your bill was cross-referenced against six federal data sources: the CMS Physician Fee Schedule (Medicare allowed rates), NADAC (pharmacy acquisition cost benchmarks), federally-required Hospital Price Transparency files (cash and insurance-negotiated rates per facility), CMS National Correct Coding Initiative bundling edits, CMS Hospital Compare (facility quality and safety metrics), and IRS Publication 78 (501(c)(3) charity-care eligibility for non-profit hospitals). Patterns associated with potential billing errors were flagged for your review.

WHAT THIS REPORT IS NOT

MediBill Saver is self-help software — not a substitute for a credentialed medical billing advocate, attorney, or CPA. Nothing in this report constitutes legal, medical, or billing advice. Every decision and action is yours. The dispute letters in this document are starting points; your specific situation may warrant additional details.

Thank you for trusting MediBill Saver. We hope this report saves you money and time.