

Formal Complaint, Request for Records, and Billing Review

Date: [DATE]

To: [PROVIDER PATIENT RELATIONS / COMPLIANCE OFFICE]

Copy to: [PROVIDER BILLING OFFICE]; [HEALTH PLAN / INSURER]

Re: [PATIENT NAME]; Date of Birth: [DATE OF BIRTH]; Account/MRN: [MEDICAL RECORD NUMBER]; Dates of Service: [DATES OF SERVICE]

Dear [RECIPIENT NAME OR TITLE]:

I submit this formal complaint and request for review concerning care, treatment discussions, documentation, and billing associated with my treatment by [PROVIDER / FACILITY NAME]. I request a prompt, written response and preservation of all related records.

1. Basis for This Complaint

I have reviewed publications describing purported “scalar wave,” “vibrational energy,” “bioenergetic,” and AI-supported wellness or mental-health interventions, including *Scalar Wave: Harnessing Vibrational Energy and Wellness* and *Augmenting Scalar Wave Vibration Energy and AI-Driven Therapies for Managing Obsessive-Compulsive Disorder (OCD)*. These publications describe concepts and potential applications involving scalar-wave or bioenergetic approaches, but they do not establish that a particular intervention is clinically validated, medically necessary, appropriate for me, or authorized by me.

I am concerned that a treatment, device, service, assessment, referral, or charge associated with [IDENTIFY THE TREATMENT, DEVICE, SERVICE, OR CHARGE] may have been discussed, performed, documented, or billed without my fully informed and documented authorization. At this time, I am requesting clarification and records; I am not making a final factual allegation as to any individual’s intent or conduct.

My specific concerns are as follows:

1. I do not recall receiving a clear explanation of the nature, purpose, expected benefits, material risks, alternatives, evidence base, provider qualifications, cost, or insurance status of [TREATMENT OR SERVICE].
2. I do not recall providing informed consent for [TREATMENT OR SERVICE], including consent for any use of an energy-based device, digital or AI-supported tool, research-related activity, nonstandard wellness modality, medication, procedure, or related data collection, if applicable.
3. I dispute or question the accuracy, authorization, medical necessity, coding, amount, or insurer submission of the following charge(s) or claim(s): [LIST CHARGE DATE, AMOUNT, PROVIDER, CPT/HCPCS/DIAGNOSIS CODE, CLAIM NUMBER, AND EOB REFERENCE IF KNOWN].

4. I request confirmation whether any part of my care was described, treated, marketed, documented, or billed as “scalar wave,” “vibrational,” “bioenergetic,” “wellness,” “quantum,” AI-driven, investigational, research-related, or otherwise outside ordinary evidence-based clinical care.

2. Requested Investigation and Written Response

Please conduct an independent review of the matters above and provide a written response addressing each of the following:

1. Identify every service, treatment, device, test, medication, digital tool, wellness modality, and clinical or nonclinical assessment provided, ordered, recommended, scheduled, or billed in connection with the dates of service identified above.
2. State whether any service was investigational, research-related, nonstandard, not generally accepted as standard clinical care, or supported by claims concerning scalar waves, vibrational energy, bioenergetics, quantum healing, AI-driven therapy, or similar concepts.
3. Identify the clinician or other person who recommended, ordered, performed, supervised, documented, coded, or billed each service.
4. Identify the consent process used for each relevant service, including the date, person obtaining consent, information disclosed about risks, benefits, alternatives, costs, and insurance coverage, and the location of every signed, electronic, verbal, or implied-consent record.
5. State whether the service was medically necessary, the clinical basis for that conclusion, and whether prior authorization, referral, utilization review, or other approval was requested or obtained.
6. Identify each claim submitted to any health plan, insurer, government program, or other payer, including the submission date, amount charged, amount paid, procedure and diagnosis codes, modifier codes, rendering provider, billing provider, claim number, and the current claim status.
7. Confirm whether any charges or claims will be placed on hold while this matter is reviewed. If an error, unsupported charge, duplicate charge, unauthorized service, or inaccurate coding is identified, promptly correct the record and reverse, withdraw, or resubmit the affected claim as appropriate.

3. Request for Records

Please provide complete, legible copies of the following records for the dates of service listed above and any related period:

1. The complete medical record, including intake materials, history and physicals, progress notes, treatment plans, referrals, orders, prescriptions, nursing notes, procedure notes, discharge materials, and communications.

2. Every consent, authorization, acknowledgment, refusal, privacy authorization, financial-responsibility form, treatment-specific consent, research consent, and electronic-signature audit trail.
3. Device logs, treatment logs, medication-administration records, clinical decision-support outputs, AI-tool outputs or reports incorporated into my care, and any records identifying data collected, used, disclosed, or transmitted in connection with the service.
4. All billing records, charge-master entries, itemized statements, coding worksheets, encounter forms, claim forms, remittance advice, explanations of benefits, prior-authorization documents, utilization-review documents, and correspondence with any payer.
5. Any policy, protocol, training material, marketing material, clinical guideline, or written description that governed or described the relevant treatment or service.
6. Any incident report, quality-assurance review, compliance review, billing audit, complaint record, or internal investigation concerning my care or the disputed charges, to the extent disclosable by law.

Please provide the records electronically in searchable PDF format, with native electronic records or audit logs where reasonably available, to *[EMAIL ADDRESS]*. If you contend that any requested item cannot be produced, identify the item, the reason, the legal or policy basis for withholding it, and the custodian of the record.

4. Preservation Notice

Please preserve all potentially relevant information, including paper records; electronic health-record entries; metadata; audit logs; portal messages; emails; text messages; call recordings; device logs; billing and coding records; claims-submission records; consent records; video or audio recordings; and communications with insurers, vendors, contractors, or affiliates. Do not alter, overwrite, delete, or destroy any such information while this complaint is pending.

5. Requested Resolution

Pending completion of the review, I request that *[PROVIDER / FACILITY NAME]*:

1. refrain from further collection activity on the disputed charges;
2. ensure that no additional disputed claim is submitted or re-submitted without written notice to me;
3. provide a complete written explanation of the treatment, consent, documentation, and billing identified above;
4. correct any inaccurate medical-record entry, coding entry, charge, or claim; and
5. identify a single point of contact for this complaint.

This complaint is made in good faith based on the information presently available to me. I reserve all rights and remedies. Nothing in this letter is an admission that I received, authorized, consented to, or am financially responsible for any disputed service or charge.

Please acknowledge receipt within *[10] CALENDAR DAYS* and provide a substantive written response within *[30] CALENDAR DAYS*.

Sincerely,

[PATIENT NAME]
[ADDRESS]
[PHONE NUMBER]
[EMAIL ADDRESS]

Attachments:

1. *[EXPLANATION OF BENEFITS / BILL / CLAIM NOTICE]*
2. *[RELEVANT PORTAL MESSAGE OR CORRESPONDENCE]*
3. *[TIMELINE OF EVENTS]*
4. *[OTHER SUPPORTING DOCUMENTS]*