



HEALTH & WORK

Medical Bill-EOB Reconciliation and Correction Workbook

After an accident, compare a provider's bill with the insurer's explanation of benefits and payment receipts, identify a specific mismatch, and obtain a documented correction or a clear escalation destination.

WHAT THIS WORKBOOK HELPS YOU DO

01

Complete your
encounter-to-document match
sheet

02

Complete your three-way
amount bridge

03

Complete your discrepancy and
correction request

For people handling accident-related paperwork and preparing clear, evidence-backed questions.

Use it on screen or on paper. Save a personal copy before entering information. Blank response areas are fillable; printed copies work just as well. Keep completed copies private.

Scope. Educational organization tools, not legal, medical, tax or financial advice. No claim result, coverage decision or payment is promised. Verify policy language, current local rules and all deadlines with the appropriate professional or official source.



START HERE

Start with a clear working file

Work on one claim, account or issue at a time. Keep originals unchanged and label working copies with a short evidence ID. Complete the guidance in order, then use the worksheets to turn questions into an organized next step.

A practical order

- 01** Read the four guidance pages before filling the worksheets. Mark facts you can support and questions that still need an answer.
GUIDANCE / PAGES 03-06
- 02** Use the fictional examples to check your method. Their facts and dollar amounts do not describe your claim or predict an outcome.
EXAMPLES / PAGE 07
- 03** Complete the four working sheets, then use the readiness check and next-step page. Duplicate a worksheet when you need another record.
WORKSHEETS / PAGES 08-11

Protect your information

Store completed copies somewhere private. Use a claim or account suffix when a full identifier is unnecessary. Share only relevant copies through a verified recipient and appropriate channel. A saved PDF can contain personal information even when it is not open on screen.

Before a deadline. Do not wait to finish this workbook when a notice, release, court paper or policy deadline needs attention. Verify the actual requirement and seek qualified help promptly.



GUIDANCE 1

01

Choose the correct lane

Start by naming the document in front of you. An explanation of benefits (EOB) describes how a health plan processed a claim; it is not an instruction to pay the insurer. A provider statement requests payment on an account. A collection letter or court paper may require a different response with a separate deadline. Write down what you received, who sent it and when. Then state the problem in one sentence: "My receipt is not credited," "The billed balance differs from the EOB," or "I cannot afford the stated balance." These are different problems. This workbook addresses document mismatches; the final guidance section helps you move other problems to the appropriate assistance channel.

Build the three-document source set

Make a small source packet for one provider account before expanding to the entire accident file. Place the itemized bill first, the corresponding EOB second and your receipts third. Add corrected statements behind the originals, labeled by issue date. If the provider supplies only a total, ask for the underlying itemization and payment ledger. If you have no EOB, ask the plan whether it has received and processed a claim for those services. Record the answer rather than filling missing numbers with estimates. Keep the originals intact. On working copies, use page labels so another person can follow each amount back to its source without searching through unrelated medical records.

Use one provider account; keep each amount traceable to its source.



Sources for this page: [1], [2]. See the linked source guide.



GUIDANCE 2

02

Match an encounter to billing lines

A single hospital visit can produce more than one account. Match the organization named on the bill, the service date, the claim reference and the description before comparing dollar amounts. Where units or service codes appear, copy them exactly and ask the billing office to explain unfamiliar entries. Two lines on the same date are a reason to ask a question, not proof of duplicate billing. If a revised claim replaces an earlier version, keep both and mark which version the plan says is current. Mark an unmatched line as needing confirmation until someone with access to the underlying account explains it. Do not force a match just to make the totals balance.

Read the money columns

Copy each number into the column that describes it. A provider's original charge and a plan's allowed charge can be different figures. The plan payment, the patient-responsibility amount and a payment you already made answer different questions. Use the EOB's own labels and retain its remark-code explanation. The worksheet deliberately keeps these figures separate so a discount is not subtracted twice or a copay treated as another insurance payment. Do not calculate a balance from an incomplete EOB by inventing a missing adjustment. When the document does not explain an amount, mark it "unverified" and write the question you need answered. This arithmetic checks account consistency; it does not decide legal liability.

RELATED WORKING SHEETS

- [Encounter-to-document match sheet](#)
- [Three-way amount bridge](#)

Sources for this page: [1], [2]. See the linked source guide.



GUIDANCE 3

03

Classify the discrepancy

Choose the narrowest discrepancy category supported by the documents. “Receipt not reflected” is stronger and clearer than “The whole bill is wrong” when you have a dated copay receipt. For an unfamiliar service, quote its date and description and ask what it represents. For a higher provider balance, identify the EOB amount and ask the provider to reconcile the difference. Note whether the account is still being processed or whether the plan issued a revision. Keep an uncertainty box for missing facts. Avoid accusations about fraud or intentional overcharging; this workbook cannot establish them. The goal is a verifiable explanation or correction, with each request tied to one identifiable entry.

Request a specific correction

Before calling, prepare the account reference, disputed line and two source documents. A useful opening is: “I am asking you to reconcile this statement with these records.” Explain the discrepancy briefly, ask what account action is needed and request a written response. If a supervisor or another department must act, record its verified contact details and reference number. Ask whether billing or collection activity can be placed on hold while the question is reviewed, but do not treat the request as approval. Record any confirmed hold's scope and end date. After the call, send a concise factual summary through the provider's verified channel and retain proof of delivery.

RELATED WORKING SHEETS

- Discrepancy and correction request
- Three-way amount bridge

Sources for this page: [1], [2]. See the linked source guide.



GUIDANCE 4

04

Verify the response

When someone says the account has been corrected, ask for the document that shows the result. Reconcile the updated statement against the original issue rather than checking only that the total decreased. Verify that a receipt was assigned to the correct account, an adjustment was applied once and any revised EOB matches the provider's understanding. If the provider promises a refund, record the amount and expected method, then verify actual receipt separately. Keep pending items open until supported by documentation. If the explanation resolves a misunderstanding rather than changes a charge, write down why the original balance is supported. An accurate conclusion can be "explained, no correction," not only "bill reduced."

Route unresolved issues and close the file

If the issue remains unresolved, prepare a one-page handoff: the service, documents received, exact discrepancy, requests already made and answer still needed. Account-entry questions usually begin with provider billing; plan-processing questions begin with member services. A possible prohibited surprise bill calls for the Centers for Medicare & Medicaid Services (CMS) or applicable state/plan assistance route. A coverage denial may have its own appeal instructions. A collection notice or lawsuit deserves prompt, separate attention; sending a billing question does not automatically suspend it. At closure, store the final statement, relevant EOB, receipts and written outcome together. Keep the uncertainty register if any issue remains rather than giving the file a misleading "all clear."

RELATED WORKING SHEETS

- Resolution verification and handoff
- Three-way amount bridge

Sources for this page: [1], [2]. See the linked source guide.



FICTIONAL EXAMPLES

Work through the examples

These invented cases demonstrate the method. They are not case results, estimates of what you will receive or statements of universal rights.

01 Fictional: uncredited copay

The EOB shows a \$250 charge, \$180 allowed amount, \$120 plan payment and \$60 patient responsibility. A dated receipt proves \$25 was already paid. The provider still bills \$60. The working residual is \$35 and the question is whether the \$25 was credited to this encounter. Request the account ledger, attach the receipt and verify the corrected \$35 statement. Do not subtract the \$70 contractual adjustment a second time.

02 Fictional: apparent duplicate that needs verification

Two \$110 entries share a service date but use different provider names. Rather than label them duplicates, ask for descriptions and identify whether one is a facility component and one a professional service. Keep the issue unresolved until the provider explains it.



WORKSHEET 1

01

Encounter-to-document match sheet

Create one copy per matchable service line; do not combine a facility and a physician account.

Provider/facility and account suffix

Service date and description

Bill issue date/version

Claim number

EOB date/version

Line or page reference

Payment receipt/date

Matched / missing / needs confirmation

[Related guidance: Choose the correct lane](#)



WORKSHEET 2

02

Three-way amount bridge

Enter source figures without silently changing them. Use the arithmetic only as an account-checking aid, not a legal debt determination.

Billed charge

Allowed amount as printed

Plan payment as printed

Adjustment as printed

Patient responsibility as printed

Patient payments with receipt references

Provider balance

Reconciled residual

Unexplained difference

Related guidance: [Match an encounter to billing lines](#)



WORKSHEET 3

03

Discrepancy and correction request

Send copies, keep originals, and avoid unnecessary identifiers in routine email.

Issue type

Exact conflicting entries

Documents supporting the question

Requested explanation/correction

Recipient and verified contact

Request date/method

Case number

Hold requested/confirmed terms

Promised response date

Related guidance: [Classify the discrepancy](#)



WORKSHEET 4

04

Resolution verification and handoff

Close only when the resulting documents support the resolution, or explicitly record an unresolved handoff.

Original disputed amount

Updated bill/EOB date

Action confirmed in writing

Payment/adjustment reference

New balance

Remaining question

Next owner

Independent deadline

Closed by/date

Related guidance: [Verify the response](#)



READINESS REVIEW

Check the file before using it

REVIEW EACH ITEM BEFORE MOVING ON

- ☐ Each working figure or statement is linked to an identifiable document.
- ☐ Missing information is marked as unverified rather than estimated as fact.
- ☐ The exact question and the person or organization able to answer it are identified.
- ☐ The current document version and any conflicting version are preserved.
- ☐ Independent deadlines and the source of each deadline have been checked.
- ☐ The final written response has been compared with the original question.

What still needs attention

Open fact or decision, who can resolve it, and the source needed

Completion standard. One evidence-backed correction packet per provider account, plus a signed-off reconciliation showing the corrected bill, revised EOB if any, receipts and remaining unresolved questions.



ACTION PLAN

Write down the next step

Choose the smallest useful next step. Make the request specific enough that the recipient can locate the record and explain or address the exact issue. Keep proof of what you sent and what came back.

The exact issue or request

Evidence IDs and document versions that support the request

Verified recipient and channel

Date sent and follow-up date

What response will resolve the issue, and what still needs professional review

Separate decisions. A courtesy follow-up date is not a legal deadline. A document request does not automatically pause another requirement. Do not sign, settle, move property or disclose sensitive records merely because a box on this page is complete.



REFERENCE GUIDE

Sources and scope

The linked official sources support the educational background. The forms and examples are original organization tools. Sources were checked on October 1, 2026; policies, procedures and law may change. Recheck the current source before relying on a rule.

[1] Centers for Medicare and Medicaid Services

CMS distinguishes an EOB from a bill and explains charges, allowed charges, insurer payments, patient balance and remark codes. CMS also notes that payments already made may not appear in the EOB patient balance. The page was modified August 25, 2026.

<https://www.cms.gov/initiatives/your-patient-rights/medical-bill-rights/get-help/medical-bill-guides-resources/how-read-health-insurance-explanation-benefits>

[2] Centers for Medicare and Medicaid Services

Different billing protections and help routes apply depending on coverage and care setting; possible surprise bills follow a different route from ordinary account correction.

<https://www.cms.gov/initiatives/your-patient-rights/medical-bill-rights/know-your-medical-bill-rights>

Keep the scope clear

No guarantee that a bill is unlawful, collectible, forgiven or paused

No medical-coding diagnosis, medical-necessity assessment or instruction to change treatment

Do not withhold every payment, ignore notices or miss a separate appeal or court deadline