Medical Bill Dispute Small Claims Form

Claimant Information

Full Name

Address

Phone Number

Email

Respondent (Medical Provider) Information

Provider/Facility Name

Address

Phone Number

Disputed Bill Information

Bill/Account Number

Date of Service

Amount Disputed

Reason for Dispute

Explain why you are disputing the medical bill

Attempts to Resolve

Describe any attempts to resolve this dispute directly with the provider

Supporting Documents

List any supporting documents you are submitting (e.g., bills, correspondence):

Declaration

I declare under penalty of perjury that the statements made in this form are true and correct to the best of my knowledge.

Signature

Date