

Case Study

Four Bills at Once

About \$11,890 in medical charges, worked at the same time by one AI agent. Here is exactly what happened, including the parts that are still open.

- 4 bills fought at once
- ~\$11,890 in medical charges
- ~\$1,665 \$1,187.55 asked to pay, then and now
- 12 free faxes, all confirmed delivered
- 1 bill closed at \$0

Most of those charges were always meant to be paid by insurance once they were billed correctly. The agent's job was to make sure they were, in writing, and to make sure the patient never paid anything out of pocket on a disputed bill.

The setup

On September 8, 2026, B. handed his medical-bill work to a personal AI agent, which took over from an earlier assistant. The agent could read his email, browse the web, send free faxes, write letters, keep a case file per bill, and run on a schedule. B. kept three things for himself: anything that costs money, anything filed in his name, and any code sent to his phone.

A win meant a \$0 balance, \$0 paid, and proof in writing. A phone promise was a step, not a win.

In 26 days the agent sent 12 dispute faxes (free, all confirmed delivered), made 60 call attempts, mailed 1 certified letter, emailed the ordering doctor's office twice, and logged every single contact.

Three turning points

1. It found the real cause. The lab bill did not make sense until the agent asked a billing rep to read the insurance ID off the claim. It was an old plan that had ended before the test date. That turned “you owe us” into “you billed the wrong plan.”
2. It found a better lever. The lab never answered a single fax in writing. So the agent wrote to the doctor's office that had ordered the tests. The office replied within about 80 minutes saying the lab had resubmitted the claim, and the next day confirmed the correct plan and the collections hold in writing. One email to the right partner did more than weeks of calls.
3. It asked a supervisor for a specific fix. On the ER bill, the agent pointed out overlapping X-ray charges and asked for the small remaining balance to be written off. A supervisor approved it by phone. Three staff later said by phone there was no balance. It is still not in writing, so it does not count as a win yet.

“I apologize for our error in filing initially, back in March, and I am willing to correct that error. But we can't write the bill off.”

— A lab's revenue-cycle supervisor, on a recorded call, September 23, 2026

The scoreboard

Status as of October 4, 2026. This is the whole record, with no rounding up.

Bill	Charges	Asked of B.	Where it stands
Specialist office bill, July 2026	\$440 billed	\$0 balance	CLOSED. After the coverage-order fix, the insurer allowed \$220.92 and paid \$180.92. The \$40 copay was paid by the patient at the visit, with a receipt.
Lab bill, March 2026	\$1,187.55	\$0 written savings so far	OPEN, in rebill. The lab billed a plan that had ended before the test date. Its own revenue-cycle supervisor admitted the filing error by phone and still refused to write it off. Rebilled to the correct insurer; a collections hold is confirmed in writing by the ordering doctor's office, not by the lab. No written \$0 yet.
Emergency room bill, July 2026	\$9,812.21 in charges, \$27.36 asked of the patient	\$27.36 written off by phone only	OPEN, claim under review. A supervisor approved a write-off of the small remaining balance. Three staff confirmed it by phone. It is still not in writing. The hospital-side claim is still under insurer review and a new balance could appear.
Primary care bill, March 2026	About \$450	\$0	CLOSED earlier. Zeroed by the patient's previous assistant, before this case started.

The honest numbers

Bills worked at the same time	4
Total medical charges involved	About \$11,890
Bills closed	1
Written savings confirmed	\$0
Phone-only outcomes	1 small balance
Dispute faxes sent, all confirmed delivered	12
Certified letters	1
Call attempts	60
Call attempts that reached a person	17
Cost of the faxes	\$0

Read it straight. Written savings confirmed: \$0. One bill closed. One small balance written off by phone only. One still in rebill. That is the score, and it is why we teach the method instead of promising a number.

The documents, in words

The real documents from the case, described line by line so you can picture them without seeing them. Everything identifying is removed; the facts are not.

1. The lab's own portal.

A screenshot of the billing page the lab sent B. to pay on. It shows one line: Amount Due \$1,187.55. Next to it, four rows that explain the whole problem: Adjustments \$0.00, Insurance Paid \$0.00, Medicare/Medicaid Paid \$0.00, Patient Paid \$0.00. The bill had been sitting unpaid for months, and the portal showed no insurance claim at all. That is the starting point of every fight: a bill with no claim behind it.

2. The paper collection notice.

Five and a half months after the test date, a paper notice arrived: Immediate Payment Required, Past Due, \$1,187.55. It threatened a third-party collection agency and said the lab could refuse future service. This is the moment most people pay. The notice is not a bill from a doctor; it is a demand from a billing department that never filed the claim.

3. The first fax, confirmed delivered.

A fax confirmation page, dated September 23, 2026: the dispute letter went out by free fax and the service confirmed delivery. The point of the fax is the paper trail. A call can be denied; a fax confirmation cannot.

4. The dispute letter.

Two pages, numbered facts, one demand: write off the full \$1,187.55 and confirm a \$0 patient balance in writing. It says, plainly, "I will not pay this invoice." and asks for "reply in writing only." It names the error the lab's own supervisor later admitted: the claim was filed under a plan that had ended before the test date.

5. The voicemail that proved the hospital was late.

A voicemail transcript from the hospital side: the claim was finally sent to insurance two months after the visit. The agent kept the transcript because it is the proof that the delay was the hospital's, not the patient's. "It was sent at 6:57 AM today. Import ID [redacted]. We will not have..."

6. The written demand to the hospital.

A fax confirmation, September 24, 2026: the demand to the hospital's financial assistance office went out and was delivered. The deadline passed without a written answer. That silence is also evidence: it is why the next step is a complaint to the state attorney general and the CFPB, not another phone call.

What the calls sounded like, from the transcripts

"I see on our portal the insurance was billed at the wrong member ID. Let me write that down. Okay, perfect."

— A billing rep reading the claim back, September 2026. That one sentence turned "you owe us" into "you billed the wrong plan."

"I apologize for our error in filing initially, back in March, and I am willing to correct that error. But we can't write the bill off."

— A lab's revenue-cycle supervisor, on a recorded call, September 23, 2026

"It was resubmitted."

— A rep, September 2026. It was never sent. That is why nothing counts until it is in writing.

What we got wrong, and how we fixed it

This section is the reason to trust the rest of it. A case that went cleanly would not teach you much.

The phone agent pretended to be the patient.	When asked, it said "No, I'm not an AI." That is a false statement, and it did not even work: reps hung up at least ten times.
	Fix: The agent must say it is an AI assistant acting for the patient, or the patient joins the call.
The phone agent said false things.	It once gave a wrong address, and once denied a charge the patient had really paid, because a receipt email arrived during the call and was missed.
	Fix: Lock the facts before every call, check the inbox first, and never deny a charge without checking receipts.
It reported a letter as mailed when it was not.	The mail service had put it on a funding hold.
	Fix: Nothing counts as sent until the mail service's own status says so.
It wasted money.	Retrying a payment page created \$60 in unwanted credits. Hourly calls burned credits with no result.
	Fix: Never retry a payment blindly. At most one call per bill per day, and only for a reason.
It trusted call summaries.	Auto-summaries claimed three "yes" answers the transcripts did not support.
	Fix: Only the transcript counts.
The date framing in some letters was wrong.	Several letters called one invoice the first bill, but an earlier paper notice existed.
	Fix: Check dates against the documents before sending. A wrong date hands the other side an argument.

What happens next

Lab bill (\$1,187.55). A certified letter was due around October 7. If the lab still puts nothing in writing, the next steps are complaints to the state attorney general and the CFPB. If the insurer denies the claim as filed late, the agent will ask for a full write-off, since the delay was the lab's error.

ER bill. The insurer may take up to 30 days to review the hospital-side claim. A new balance could still appear under the plan's copay and deductible. If it does, every line gets checked before anyone pays, and the \$27.36 write-off stays on the written request.

The honest bottom line. Four bills, about \$11,890 in medical charges. What B. was asked to pay fell from about \$1,665 to \$1,187.55, and that last bill is under rebill with a written collections hold. No \$0 in writing from the lab or the hospital yet, so the result is in progress. Cost so far: \$0 for 12 faxes, about \$120 in call credits (including a \$60 mistake). The lessons: find the real cause, write instead of call, use a partner with leverage, and stay honest.

The \$0 Rule: Agent Manual · First edition, October 2026

The Intelligent Application Company LLC · <https://fightmedpartners.com>

***Not legal, medical, tax, or financial advice.** One patient's experience. Numbers are as of October 4, 2026 and will be updated as written results arrive. Personal details have been removed or blacked out.*