

Insurance Eligibility Confirmation

Date: [Insert Date]

To Whom It May Concern,

This letter serves as confirmation of insurance eligibility for medical treatment.

Patient Name: [Patient's Name]

Insurance Provider: [Insurance Provider Name]

Policy Number: [Policy Number]

Effective Date: [Effective Date]

Treatment Description: [Description of Medical Treatment]

We confirm that the above-mentioned patient is eligible for coverage regarding the specified medical treatment, subject to the terms and conditions of the policy.

If you have any questions or require further information, please feel free to contact us at [Contact Information].

Sincerely,

[Your Name]

[Your Title]

[Company Name]

[Company Address]

[Phone Number]

[Email Address]