Verification of Benefits

Date: [Insert Date]

[Recipient Name]

[Recipient Address]

[City, State, Zip Code]

Dear [Recipient Name],

This letter is to confirm the verification of benefits for clinical procedures for [Patient Name], ID: [Patient ID]. Below are the details of the covered benefits:

Patient Information

Patient Name: [Patient Name]

Policy Number: [Policy Number]

Date of Birth: [Patient DOB]

Procedure Information

Procedure Name: [Procedure Name]

Procedure Code: [Procedure Code]

Scheduled Date: [Scheduled Date]

Benefits Summary

Deductible: [Deductible Amount]

Coinsurance: [Coinsurance Percentage]

Copayment: [Copayment Amount]

Covered Services: [List of Covered Services]

Please note that this verification is based on the information currently available and is subject to the terms of the insurance policy. Should you have any questions or require further assistance, feel free to contact our office at [Contact Number].

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Title]

[Your Organization]

[Organization Contact Information]