Benefits Verification Letter

Date: [Insert Date]

To: [Healthcare Provider's Name]
[Healthcare Provider's Address]
[City, State, Zip Code]

Re: Benefits Verification for [Patient's Name]
Patient ID: [Patient ID]

Dear [Healthcare Provider's Name],

This letter is to confirm the benefits verification for the healthcare services provided to the above-named patient. According to our records, the following benefits are available:

- Plan Type: [Insert Plan Type]
- Coverage Start Date: [Insert Start Date]
- Coverage End Date: [Insert End Date]
- Deductible: [Insert Deductible Amount]
- Co-payment: [Insert Co-payment Amount]
- Co-insurance: [Insert Co-insurance Percentage]
- Out-of-Pocket Maximum: [Insert Amount]

Please note that pre-authorization may be required for certain services. We advise you to verify that all services fall under the patient's plan coverage.

If you have any questions or need further clarification, please do not hesitate to contact us at [Contact Information].

Thank you for your attention to this matter.

Sincerely,
[Your Name]
[Your Job Title]
[Insurance Company Name]
[Contact Information]