Health Insurance Provider Verification Notice

Date: [Insert Date]

To: [Recipient's Name]

[Recipient's Address]

[City, State, ZIP Code]

Dear [Recipient's Name],

We are writing to inform you that we have received a request for verification of your health insurance coverage. Below are the details of your policy:

- Policy Number: [Insert Policy Number]
- Provider Name: [Insert Provider Name]
- Coverage Effective Date: [Insert Effective Date]
- Coverage Expiry Date: [Insert Expiry Date]
- Type of Coverage: [Insert Type (e.g., individual, family)]

Please review the information above for accuracy. If you have any questions or require further assistance, do not hesitate to contact our customer service department at [Insert Phone Number] or [Insert Email Address].

Thank you for choosing [Insurance Provider Name].

Sincerely,

[Your Name]

[Your Position]

[Insurance Provider Name]

[Provider Address]

[City, State, ZIP Code]

[Provider Phone Number]