Vascular Assessment Insurance Verification Request

Date: [Insert Date]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Dear [Insurance Company Representative's Name],

I am writing to request verification of insurance benefits for a vascular assessment scheduled for [Patient's Name], [Patient's Date of Birth], [Patient's Insurance ID Number].

The procedure is medically necessary due to [brief explanation of medical necessity]. Please find the details of the procedure below:

- Procedure: Vascular Assessment
- Date of Service: [Scheduled Date]
- Referring Physician: [Referring Physician's Name]
- CPT Code: [CPT Code]

We kindly request confirmation of coverage, any pre-authorization requirements, and estimated patient responsibility. If additional information is needed, please do not hesitate to contact me at [Your Phone Number] or [Your Email Address].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name]

[Your Title]

[Your Organization Name]

[Your Organization Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email Address]