Insurance Coverage Details

Date: [Insert Date]

To: [Patient's Name]

Address: [Patient's Address]

Dear [Patient's Name],

We are writing to provide you with the details regarding your insurance coverage for the reconstructive surgery you are considering. After reviewing your policy, we have confirmed the following coverage information:

Procedure Overview

Procedure Name: [Insert Procedure Name]

Estimated Date of Surgery: [Insert Date]

Insurance Coverage Breakdown

- Coverage Type: [Insert Coverage Type]
- Deductible: [Insert Deductible Amount]
- Coinsurance: [Insert Coinsurance Percentage]
- Out-of-Pocket Maximum: [Insert Out-of-Pocket Maximum]
- Pre-authorization Required: [Yes/No]

Provider Information

Surgeon: [Insert Surgeon's Name]

Facility: [Insert Facility Name]

Please ensure that all necessary documentation and authorization requests are submitted prior to the surgery date to avoid delays in processing your claims. If you have any questions or require further assistance, do not hesitate to reach out to our office.

Thank you for choosing [Insurance Company Name].

Sincerely,

[Your Name]

[Your Position]

[Insurance Company Name]

[Contact Information]