

Health License Verification

Date: [Insert Date]

To Whom It May Concern,

This letter is to confirm the health license status of [Provider's Name], practicing as [Provider's Specialty] under the license number [License Number].

Provider's details:

- Name: [Provider's Name]
- Address: [Provider's Address]
- Contact Number: [Provider's Contact Number]
- License Expiry Date: [Expiry Date]

This verification is requested for the purpose of [Insurance Company Name]'s review of the provider's credentials for insurance purposes.

Please feel free to contact us at [Your Contact Information] for any further inquiries.

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Title]

[Your Organization]

[Your Contact Information]