Health Insurance Coverage Verification

Date: [Insert Date]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

To Whom It May Concern,

I am writing to request verification of health insurance coverage for the following individual:

Patient Name: [Patient's Full Name]
Patient ID: [Patient ID or Policy Number]
Date of Birth: [Patient's Date of Birth]

Please confirm the coverage details including effective dates, policy benefits, and any out-of-pocket costs for services rendered. This information is required for [reason for verification, e.g., a scheduled medical procedure, ongoing treatment, etc.].

Thank you for your prompt attention to this matter. Please send the requested information to the address provided below or contact me directly at [Your Phone Number] or [Your Email Address].

Sincerely,

[Your Name]
[Your Title (if applicable)]
[Your Organization (if applicable)]
[Your Address]
[City, State, Zip Code]