Medical Coverage Verification Request

Date: [Insert Date]

To: [Insurance Company Name]

Attn: [Claims Department or Specific Contact Name]

[Insurance Company Address]

[City, State, Zip Code]

Patient Name: [Patient's Full Name]

Patient ID: [Patient's Insurance ID]

Date of Birth: [Patient's DOB]

Dear [Insurance Company/Specific Contact Name],

I am writing to request verification of medical coverage for the upcoming hospitalization of the above-mentioned patient. The hospitalization is scheduled for [Insert Date] at [Hospital Name] for [Brief Description of the Procedure].

Please provide confirmation of the patient's coverage for this admission, including any deductibles, copayments, and out-of-pocket maximums that may apply. This information is crucial for addressing any financial concerns prior to the procedure.

Should you require any additional information or documentation, 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/Position]

[Your Institution/Practice Name]

[Your Institution/Practice Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email Address]