Medical Expense Reimbursement Request

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email]

[Your Phone Number]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Dear [Insurance Company Contact or Claims Department],

I am writing to request reimbursement for dental and vision care expenses incurred during the past [insert timeframe]. The details of the expenses are as follows:

Dental Expenses:

- Date of Service: [Insert Date]
- Provider: [Insert Provider Name]
- Amount: $[Insert Amount]
- Description of Service: [Insert Description]

Vision Expenses:

- Date of Service: [Insert Date]
- Provider: [Insert Provider Name]
- Amount: $[Insert Amount]
- Description of Service: [Insert Description]

Attached are all relevant receipts and documentation supporting my claim for reimbursement.

Thank you for your prompt attention to this matter. If you require any further information, please feel free to contact me.

Sincerely,

[Your Name]