

Medical Expense Reimbursement Request

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

To: [Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Policy Number: [Insert Policy Number]

Claim Number: [Insert Claim Number]

Dear Claims Department,

I am writing to formally request reimbursement for medical expenses incurred on [insert date].
The details of the expenses are as follows:

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

Enclosed are the receipts and relevant documents supporting my claim. I appreciate your attention to this matter and look forward to your prompt response.

Thank you for your time.

Sincerely,

[Your Signature]

[Your Printed Name]