Medical License Verification

Date: [Insert Date]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

To Whom It May Concern,

This letter is to confirm the verification of medical licensure for Dr. [Full Name], who is a provider under our network.

Dr. [Last Name] holds a medical license issued by the [State Licensing Board] with the license number [License Number]. The license was issued on [Issue Date] and is currently valid until [Expiration Date].

Please feel free to contact us for any further information or verification you may require. Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Title]

[Your Organization]

[Your Contact Information]