Insurance Co-Payment Verification Letter

Date: [Insert Date]

To: [Patient's Name]

Address: [Patient's Address]

Dear [Patient's Name],

We are writing to inform you about the co-payment details regarding your upcoming medical treatment at [Facility/Provider Name]. Below are the specifics of your co-payment:

Co-Payment Information

- Insurance Provider: [Insurance Company Name]
- Policy Number: [Policy Number]
- Co-Payment Amount: [Co-Payment Amount]
- Effective Date: [Effective Date]

Please ensure that you bring the necessary payment on the day of your appointment. If you have any questions regarding this co-payment or your coverage, feel free to contact us at [Phone Number] or [Email Address].

Thank you for choosing [Facility/Provider Name]. We look forward to serving you.

Sincerely,

[Your Name]
[Your Title]
[Facility/Provider Name]
[Contact Information]