Insurance Verification Request

Date: [Insert Date]

To: [Insurance Company Name]

Attention: [Claims Department/Specific Person's Name]

Address: [Insurance Company Address]

City, State, Zip: [City, State, Zip]

Dear [Insurance Company Representative],

We are requesting verification of benefits for our patient, [Patient Name], who requires respiratory therapy services.

Patient Information:

- Name: [Patient Name]
- Date of Birth: [Patient DOB]
- Policy Number: [Patient Policy Number]
- Group Number: [Patient Group Number]

Service Request:

- Type of Service: Respiratory Therapy
- Requested Start Date: [Start Date]
- Duration of Service: [Number of Sessions/Duration]

Kindly provide us with the coverage details, including any applicable co-pays, deductibles, and authorization requirements for the respiratory therapy services indicated above.

Thank you for your prompt attention to this matter. Please feel free to contact us at [Your Phone Number] or [Your Email Address] should you need any further information.

Sincerely,

[Your Name]
[Your Title]
[Your Institution/Practice Name]
[Your Address]
[City, State, Zip]
[Your Phone Number]
[Your Email Address]