Insurance Verification Request

Date: [Insert Date]

To: [Insurance Company Name]

Address: [Insurance Company Address]

Attention: [Claims Department/Specific Contact Person]

Dear [Insurance Company Name],

I am writing to request verification of insurance coverage for an upcoming gallbladder surgery for my patient, [Patient's Full Name], who is a member of your insurance plan. Below are the pertinent details:

- **Patient Name:** [Patient's Full Name]
- **Insurance ID Number:** [Patient's Insurance ID]
- **Date of Birth:** [Patient's DOB]
- **Procedure Code:** [CPT Code for Gallbladder Surgery]
- **Provider's Name:** [Surgeon's Name]
- **Facility Name:** [Hospital/Clinic Name]
- **Scheduled Date of Surgery:** [Surgery Date]

Please confirm the coverage details at your earliest convenience, including any pre-authorization requirements and associated costs. You may contact me directly at [Your Phone Number] or [Your Email Address] if any further information is needed.

Thank you for your attention to this matter. I look forward to your prompt response.

Sincerely,

[Your Name]
[Your Title]
[Your Practice/Organization Name]
[Your Address]
[City, State, ZIP]