Insurance Verification Request

Date: [Insert Date]

[Provider's Name]
[Provider's Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]

Re: Verification of Benefits for [Patient's Name]
Policy Number: [Policy Number]
Group Number: [Group Number]

Dear [Insurance Company Representative's Name],

I am writing to request verification of benefits for my patient, [Patient's Name], who is currently seeking maximum benefit coverage for the required medical services.

Details of the services are as follows:

- Type of Service: [Service Type]
- Service Date: [Proposed Date]
- Estimated Cost: [Estimated Cost]
- Provider NPI: [Provider NPI]

Please provide information regarding:

- Eligible benefits for the requested services
- Deductibles and copays applicable
- Any necessary pre-authorization requirements

Your timely response will be greatly appreciated to facilitate the care of my patient. Thank you for your attention to this matter.

Sincerely,

[Your Name]
[Your Title]
[Your Institution/Practice]
[Address]

[City, State, Zip Code]
[Phone Number]
[Email Address]