

Debilitating Illness Coverage Examination

Date: [Insert Date]

To: [Recipient Name]

[Recipient Address]

Dear [Recipient Name],

We are writing to inform you regarding the examination required for your debilitating illness coverage. In order to proceed with your application, it is necessary to schedule a medical evaluation with one of our licensed healthcare providers.

Please find the details of your examination below:

- Date of Examination: [Insert Date]
- Time: [Insert Time]
- Location: [Insert Location]
- Provider: [Insert Provider Name]

During the examination, the healthcare provider will assess your condition and determine the extent of your coverage based on our policy guidelines.

If you need to reschedule or have any questions, please feel free to contact us at [Insert Phone Number] or [Insert Email Address]. We look forward to assisting you with your coverage needs.

Sincerely,

[Your Name]

[Your Position]

[Company Name]

[Company Address]