Authorization for Insurance Verification Request

Date: [Insert Date]

To Whom It May Concern,

I, [Your Name], hereby authorize [Insurance Company Name] to disclose my insurance information to [Provider's Name or Facility Name] for the purpose of verifying my insurance benefits.

Patient Name: [Patient's Name]

Patient Date of Birth: [Patient's DOB]

Policy Number: [Policy Number]

Effective Date: [Effective Date]

I understand that this authorization is valid until the verification process is completed, but no longer than [Specify Duration].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Address]

[Your Phone Number]

[Your Email Address]