Coverage Verification Request

Date: [Insert Date]

To Whom It May Concern,

I am writing to request verification of insurance coverage for the following patient:

Patient Name: [Insert Patient Name]
Patient ID: [Insert Patient ID]
Date of Birth: [Insert Patient Date of Birth]

Policyholder Name: [Insert Policyholder Name]
Policy Number: [Insert Policy Number]
Group Number: [Insert Group Number]

Please provide information regarding the following services:

- [Service 1]
- [Service 2]
- [Service 3]

Your prompt response will be appreciated as it will assist us in providing the necessary care for the patient.

Thank you for your assistance.

Sincerely,
[Your Name]
[Your Position]
[Your Contact Information]
[Your Practice/Facility Name]