

Out-of-Network Reimbursement Request

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, ZIP Code]

[Your Email]

[Your Phone Number]

[Insurance Company Name]

[Insurance Company Address]

[City, State, ZIP Code]

Dear Claims Department,

I am writing to formally request reimbursement for medical services received from an out-of-network provider on [date of service]. My policy number is [your policy number].

The details of the services are as follows:

- **Provider Name:** [Provider's Name]
- **Service Type:** [Service Description]
- **Date of Service:** [Date]
- **Total Amount Charged:** \$[amount]

Enclosed are copies of the receipts and any necessary documentation to support my claim.

According to my policy, I understand that [briefly mention relevant coverage details]. I would appreciate your prompt attention to this matter and look forward to your reply.

Thank you for your assistance.

Sincerely,

[Your Name]