Allergy Testing Insurance Coverage Information

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Address: [Insert Patient Address]

Insurance Provider: [Insert Insurance Provider Name]

Policy Number: [Insert Policy Number]

Dear [Patient's Name],

We are writing to inform you about the insurance coverage details regarding your recent allergy testing procedure.

Insurance Coverage Details:

- Procedure Code: [Insert Procedure Code]
- Procedure Description: Allergy Testing
- Coverage Eligibility: [Insert Coverage Eligibility]
- Deductible: [Insert Deductible Amount]
- Co-pay: [Insert Co-pay Amount]
- Out-of-Pocket Maximum: [Insert Amount]

Please review the information above and contact your insurance provider for any further clarifications regarding your coverage. Should you have any questions or need assistance, feel free to reach out to our office.

Thank you for choosing [Your Clinic Name]. We are here to support you.

Sincerely,

[Your Name]
[Your Position]
[Your Clinic Name]
[Contact Information]