Health Insurance Coverage Verification

Date: [Insert Date]

To: [Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Dear [Insurance Representative's Name],

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

Patient Name: [Patient's Full Name]

Policy Number: [Patient's Policy Number]

Date of Birth: [Patient's Date of Birth]

Effective Date of Coverage: [Effective Date]

We would like to verify the following information:

- Current coverage status
- Benefits available
- Any applicable co-pays or deductibles

Please provide this information at your earliest convenience to ensure timely processing of medical services. You may contact me at [Your Phone Number] or [Your Email Address] for any questions or additional information.

Thank you for your assistance in this matter.

Sincerely,

[Your Name]

[Your Title/Position]

[Your Organization/Practice Name]

[Your Organization Address]

[City, State, Zip Code]