

Durable Medical Equipment Coverage Approval

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Address: [Insert Patient Address]

City, State, Zip: [Insert City, State, Zip]

Insurance Provider: [Insert Insurance Provider]

Policy Number: [Insert Policy Number]

Claim Number: [Insert Claim Number]

Dear [Patient Name],

We are pleased to inform you that your request for coverage of durable medical equipment has been approved. The following equipment will be covered under your policy:

- Type of Equipment: [Insert Type]
- Model: [Insert Model]
- Quantity: [Insert Quantity]

Effective from: [Insert Effective Date]

Please ensure that you follow the guidelines for usage and maintenance outlined in your policy documents. If you have any questions, feel free to contact our customer service team at [Insert Contact Information].

Thank you for choosing [Insert Insurance Provider].

Sincerely,

[Your Name]

[Your Position]

[Insurance Provider Name]