Durable Medical Equipment Eligibility Confirmation

Date: [Insert Date]

[Patient's Name]

[Patient's Address]

[City, State, Zip Code]

Dear [Patient's Name],

We are pleased to inform you that your eligibility for durable medical equipment has been confirmed. Below are the details of your eligibility:

- **Patient ID:** [Insert Patient ID]
- **Insurance Provider:** [Insert Insurance Provider]
- **Effective Date:** [Insert Effective Date]
- **Equipment Approved:** [Insert Equipment Description]
- **Duration of Coverage:** [Insert Duration]

If you have any questions or need further assistance, please do not hesitate to contact us at [Insert Contact Information].

Thank you for choosing [Your Company Name].

Sincerely,

[Your Name]

[Your Title]

[Your Company Name]

[Your Company Address]

[City, State, Zip Code]

[Your Phone Number]