

# To Whom It May Concern,

I am writing to provide a detailed explanation of my gastrointestinal symptoms for the purpose of my insurance claim.

Patient Name: [Your Name]

Policy Number: [Your Policy Number]

Date of Service: [Date]

## Symptoms Description:

- Frequent abdominal pain and cramping
- Persistent bloating and gas
- Diarrhea or constipation
- Nausea and vomiting
- Loss of appetite

## Medical Evaluation:

Based on my consultation with [Doctor's Name] on [Date], these symptoms have significantly impacted my daily life and ability to perform routine activities. I have undergone [list any tests, e.g., endoscopy, colonoscopy] to help diagnose the underlying issues.

## Treatment Plan:

Following my medical evaluations, my healthcare provider has recommended [outline any treatments or medications prescribed], which are ongoing to manage my symptoms effectively.

## Conclusion:

Due to the severity and persistence of my gastrointestinal symptoms, I kindly request the approval of my insurance claim to support my medical treatment and associated costs.

Thank you for your attention to this matter. Should you require further information, please do not hesitate to contact me at [Your Phone Number] or [Your Email Address].

Sincerely,

[Your Name]

[Your Address]

[City, State, Zip Code]