

Health Insurance Verification Request

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email Address]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Dear [Insurance Company Representative's Name],

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

Patient's Name: [Patient Name]

Patient's Date of Birth: [DOB]

Policy Number: [Policy Number]

Group Number: [Group Number]

Please confirm the patient's eligibility and benefits for the necessary services. Additionally, I would appreciate any details regarding co-payments, deductibles, and coverage limitations.

If you require any further information, please do not hesitate to contact me at the phone number or email provided above.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name]

[Your Title/Profession]

[Your Organization/Practice Name]