

# Patient Eligibility Verification

Date: [Insert Date]

To: [Insurance Company Name]

Address: [Insurance Company Address]

City, State, Zip: [Insurance Company City, State, Zip]

Re: Eligibility Verification for Claim

Dear [Insurance Representative's Name],

This letter is to verify the eligibility of our patient, [Patient's Full Name], born on [Patient's Date of Birth], for insurance coverage under policy number [Policy Number].

Details for the verification are as follows:

- Patient ID: [Patient ID]
- Service Date: [Service Date]
- Procedures/Services Rendered: [List of Procedures]

Please confirm the patient's eligibility and any applicable benefits for the services rendered. Feel free to contact us at [Your Phone Number] or [Your Email Address] should you require any further information.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name]

[Your Title]

[Your Facility/Practice Name]

[Your Facility/Practice Address]

[Your Facility/Practice Phone Number]