Patient Eligibility Verification

Date: [Insert Date]

To: [Insurance Company Name]

Address: [Insurance Company Address]

Re: Patient Eligibility Verification Request

Policyholder: [Patient's Policyholder Name]

Patient: [Patient's Name]

Date of Birth: [Patient's Date of Birth]

Insurance Policy Number: [Policy Number]

Dear [Insurance Representative's Name],

We are writing to request verification of eligibility for outpatient services for the above-mentioned patient. Our facility, [Your Facility Name], is planning to provide [describe services, e.g., physical therapy, outpatient surgery, etc.] starting on [date].

Please confirm the following:

- Eligibility for outpatient services.
- Coverage details for the proposed services.
- Any relevant copayment or coinsurance requirements.

Thank you for your prompt attention to this request. Please contact us at [Your Contact Number] or [Your Email Address] should you require any further information.

Sincerely,

[Your Name]

[Your Title]

[Your Facility Name]

[Your Facility Address]