

Patient Eligibility Verification Request

Date: [Insert Date]

To: [Insurance Company Name]

Attention: [Claims Department/Pre-Authorization Department]

Address: [Insurance Company Address]

Re: Patient Eligibility Verification for Pre-Authorization

Patient Name: [Patient's Full Name]

Patient ID: [Patient's ID Number]

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

Policy Number: [Insurance Policy Number]

Dear [Insurance Company Representative],

I am writing to request confirmation of eligibility for services provided to the above-named patient. We are seeking to initiate a pre-authorization request for the following procedure:

- Procedure: [Name of Procedure]
- Date of Service: [Projected Date]
- Provider: [Name of Provider or Facility]
- Provider NPI: [Provider's NPI Number]

We kindly request that you verify the patient's eligibility and benefits for this procedure, and provide us with any pre-authorization requirements at your earliest convenience.

Please feel free to contact me at [Your Phone Number] or [Your Email Address] should you need any further information to process this request.

Thank you for your attention to this matter.

Sincerely,

[Your Full Name]

[Your Title]

[Your Practice/Organization Name]

[Your Address]