Patient Eligibility Verification for Specialty Medications

Date: [Insert Date]

To: [Recipient's Name]

From: [Your Name / Your Organization]

Subject: Patient Eligibility Verification Request

Dear [Recipient's Name],

I am writing to request verification of eligibility for specialty medications for our patient, **[Patient's Name]**, who is currently under my care.

Patient Information:

- **Date of Birth:** [Patient's Date of Birth]
- **Insurance Provider:** [Insurance Provider Name]
- **Policy Number:** [Policy Number]
- **Diagnosis:** [Diagnosis]

The medications required are as follows:

- [Medication Name 1] - [Dosage/Instructions]
- [Medication Name 2] - [Dosage/Instructions]

We appreciate your assistance in confirming eligibility for these specialty medications at your earliest convenience. Please let us know if you require any further information or documentation.

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Title]

[Your Organization]

[Your Contact Information]