

# Patient Eligibility Verification for Telehealth Consultations

Date: [Insert Date]

To Whom It May Concern,

This letter is to verify the eligibility of [Patient's Full Name] for telehealth consultations. The patient has been experiencing [briefly state medical issue] and requires access to telehealth services for effective management.

Patient Information:

- Name: [Patient's Full Name]
- Date of Birth: [Patient's DOB]
- Insurance Provider: [Insurance Provider Name]
- Policy Number: [Insurance Policy Number]

According to our records, the patient meets the necessary criteria for telehealth consultations, including:

- Verified insurance coverage for telehealth services
- Current diagnosis that warrants remote consultation

Please contact our office at [Office Phone Number] or [Office Email] for any further information or clarification.

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Title]

[Your Practice Name]

[Practice Address]

[Practice Phone Number]