

Insurance Coverage Details

Date: [Insert Date]

[Client's Name]

[Client's Address]

[City, State, Zip Code]

To Whom It May Concern,

This letter serves as a notification of insurance coverage details for genetic counseling services provided to [Client's Name].

Insurance Provider:

[Insurance Company Name]

Policy Number:

[Insert Policy Number]

Coverage Details:

- Service: Genetic Counseling
- Provider: [Provider's Name]
- Date of Service: [Insert Date]
- Coverage Status: [Covered/Not Covered]
- Co-pay: [Insert Amount]
- Deductible: [Insert Amount]

Addition Information:

For any questions regarding coverage or claims, please contact [Insurance Company Contact Information].

Best Regards,

[Your Name]

[Your Position]

[Your Contact Information]