

Benefits Verification Letter

Date: [Insert Date]

[Your Name]

[Your Title]

[Your Organization]

[Organization Address]

[City, State, Zip Code]

[Phone Number]

[Email Address]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Dear [Insurance Representative's Name],

I am writing to request verification of benefits for our patient, [Patient's Name], whose policy number is [Policy Number]. We would greatly appreciate your assistance in confirming the following details:

- Type of coverage: [Insert coverage details]
- Effective date of coverage: [Insert date]
- Deductibles and co-payments: [Insert details]
- Preauthorization requirements: [Insert details]
- Any exclusions or limitations: [Insert details]

Please provide a written response at your earliest convenience to ensure timely processing of [Patient's Name]'s claims. You may contact me via phone at [Your Phone Number] or email at [Your Email Address] for any further information needed.

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Title]