

# Insurance Eligibility Verification Request

Date: [Insert Date]

To: [Insurance Company Name]

Address: [Insurance Company Address]

City, State, Zip: [City, State, Zip]

Phone: [Insurance Company Phone Number]

Email: [Insurance Company Email Address]

Dear [Insurance Representative's Name],

I am writing to request verification of insurance eligibility for the following patient:

- **Patient's Name:** [Patient's Full Name]
- **Date of Birth:** [Patient's Date of Birth]
- **Policy Number:** [Patient's Policy Number]
- **Group Number:** [Patient's Group Number]

We require verification to ensure that the patient is eligible for coverage for the services needed. Please provide us with the following information:

- Eligibility status
- Coverage details
- Deductibles and copayments

Thank you for your prompt attention to this matter. You can contact me at [Your Phone Number] or [Your Email Address] if you need any further information.

Sincerely,

[Your Name]

[Your Title]

[Your Organization Name]

[Your Organization Address]

[Your Organization Phone Number]