Insurance Coverage Verification

Date: [Insert Date]

[Your Name]
[Your Title]
[Your Company/Organization]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email Address]

To: [Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]

Re: Request for Insurance Coverage Verification
Claim Number: [Insert Claim Number]
Patient Name: [Insert Patient Name]
Patient Date of Birth: [Insert DOB]

Dear [Insurance Company Contact Name],

We are writing to request verification of insurance coverage for the above-mentioned patient in relation to their recent claim. Please confirm the following information:

- Policy Status: [Active/Inactive]
- Coverage Effective Date: [Insert Date]
- Policy Number: [Insert Policy Number]
- Deductibles and Co-pays: [Insert details]
- Covered Services: [Insert details]

Our records indicate that this claim was submitted on [Insert Submission Date]. Prompt verification of coverage is essential for ensuring timely processing of the claim. Please provide your response at your earliest convenience.

Thank you for your cooperation.

Sincerely,

[Your Name]
[Your Title]
[Your Company/Organization]