

Insurance Assistance Program Submission

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Email]

[Your Phone Number]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Dear [Insurance Company Representative's Name],

I am writing to submit a request for coverage under the Insurance Assistance Program for medical expenses incurred on [insert date(s) of service]. I have attached the necessary documentation to support my claim, including:

- Itemized bills from [medical provider's name]
- Proof of payment
- Relevant medical records
- Claim form (if applicable)

The total amount of medical expenses being submitted for consideration is [insert amount]. I appreciate your attention to this matter and look forward to your prompt response regarding the status of my submission.

Thank you for your assistance.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]