Health Insurance Reimbursement Request

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email Address]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Dear Claims Department,

I am writing to request reimbursement for medical expenses incurred on [Insert Date(s)] related to [Description of Medical Condition or Treatment].

Please find the details of the expenses below:

- Provider: [Provider Name]
- Service Date: [Service Date]
- Description of Service: [Description]
- Total Amount: [Total Amount]

Attached are copies of the receipts and any pertinent documentation for your review. My policy number is [Policy Number].

Thank you for your attention to this matter. I look forward to your prompt response and reimbursement.

Sincerely,

[Your Name]