[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Claims Department Address]
[City, State, Zip Code]
Re: Claim Submission for [Patient's Name]
Policy Number: [Policy Number]
Claim Number: [Claim Number] (if applicable)
Dear [Claims Adjuster's Name or "Claims Department"],
I am writing to formally submit a medical claim for services rendered to [Patient's Name] on [Date of Service]. Please find the details of the claim below:
- **Patient's Name:** [Patient's Full Name]
- **Date of Service:** [Date of Service]
- **Provider's Name:** [Provider's Full Name or Facility]
- **Type of Service:** [Description of Medical Services Provided]
- **Total Amount Charged:** [Total Amount]
- **Diagnosis Code(s):** [Applicable Diagnosis Code(s)]
- **Procedure Code(s):** [Applicable Procedure Code(s)]
Enclosed are copies of the following documents to support this claim:
1. Itemized Bill from the healthcare provider
2. Medical records relating to the treatment
3. Proof of payment (if applicable)
4. Claim form (if required by your policy)
I kindly request that you process this claim at your earliest convenience. Should you need any additional information or further documentation, please do not hesitate to contact me at [Your Phone Number] or [Your Email Address].
Thank you for your attention to this matter.
Sincerely,
[Your Signature (if mailing)]
[Your Printed Name]