[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Claims Department Address]
[City, State, Zip Code]
Subject: Medical Insurance Claim Submission
Dear Claims Department,
I am writing to submit a claim for medical expenses incurred on [Date(s) of Service] related to my treatment for [Medical Condition or Procedure].
Policyholder Information:
- Name: [Your Name]
- Policy Number: [Your Policy Number]
- Group Number: [Your Group Number] (if applicable)
Details of Service:
- Provider's Name: [Healthcare Provider's Name]
- Provider's Address: [Healthcare Provider's Address]
- Diagnosis: [Diagnosis Code/Description]
- Treatment Dates: [Start Date] to [End Date]
- Total Amount Charged: [Total Amount]
Enclosed are the following documents to support my claim:
1. Itemized bills from the healthcare provider
2. Explanation of Benefits (if applicable)
3. Any additional relevant documents
I kindly request that you process this claim at your earliest convenience. If you require further information or documentation, please do not hesitate to contact me.
Thank you for your prompt attention to this matter.
Sincerely,
[Your Signature (if sending a hard copy)]
[Your Printed Name]