

[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 Claim for Hospital Services

Dear [Claims Adjuster's Name or "Claims Department"],
I am writing to submit a medical claim for hospital services rendered to me on [date of service] at [Hospital Name]. Please find the necessary details and documentation attached.

Patient Information:

- Patient Name: [Your Name]
- Policy Number: [Your Policy Number]
- Claim Number (if applicable): [Claim Number]
- Date of Birth: [Your Date of Birth]

Service Details:

- Date of Service: [Date]
- Type of Service: [e.g., surgery, emergency care, etc.]
- Provider Name: [Doctor's Name]
- Hospital Name: [Hospital Name]
- Total Charges: [Amount]

Attached Documents:

1. Copy of the itemized bill from the hospital
2. Explanation of Benefits (EOB) from the provider
3. Relevant medical records (if necessary)
4. Any other supporting documents

I kindly request that you review this claim and process it according to my policy benefits. If you have any questions or need further information, please feel free to contact me at [Your Phone Number] or [Your Email Address].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature (if sending a hard copy)]
[Your Printed Name]