[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]
Subject: Personal Medical Claim Submission - Policy Number [Your Policy Number]
Dear [Claims Department/Specific Person's Name],
I am writing to formally submit a claim for medical expenses incurred on [Date(s) of Service]. Below are the details of my medical treatment:
Patient Information:
- Name: [Your Full Name]
- Policy Number: [Your Policy Number]
- Claim Number (if applicable): [Your Claim Number]
Provider Information:
- Provider Name: [Healthcare Provider's Name]
- Provider Address: [Healthcare Provider's Address]
- Phone Number: [Healthcare Provider's Phone Number]
Treatment Details:
- Date of Service: [Date(s) of Service]
- Description of Treatment: [Brief Description of Treatment]
- Total Amount Charged: [Total Amount]
- Amount Paid: [Amount You Paid]
Enclosed, please find the necessary documents to support my claim:
1. Copy of the medical bills
2. Explanation of Benefits (EOB) from previous insurance (if applicable)
3. [Any other supporting documents]
I would appreciate your prompt attention to this matter, and hope to receive reimbursement as soon as possible. Please feel free to contact me at any time for further information or clarification regarding this claim.
Thank you for your assistance.
Sincerely,
[Your Name]
[Your Signature (if sending a hard copy)]