

[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 Submission - [Policy/Claim Number]

Dear Claims Department,

I am writing to formally submit a medical claim for services rendered on [date of service] by [provider's name and facility]. The details of the claim are as follows:

****Patient Information:****

- Name: [Patient's Name]
- Policy Number: [Policy Number]
- Date of Birth: [Patient's Date of Birth]

****Provider Information:****

- Provider Name: [Provider's Name]
- Facility Name: [Facility Name]
- NPI Number: [Provider's NPI Number]

****Claim Details:****

- Date of Service: [Date of Service]
- Diagnosis: [Diagnosis Code(s)]
- Procedure Codes: [CPT/HCPCS Code(s)]
- Total Billed Amount: [Total Amount]
- Amount Paid: [Amount Paid]

Attached to this letter are all relevant documents, including:

1. Itemized bills
2. Explanation of Benefits (EOB) from previous claims if applicable
3. Medical records or notes from the provider (if necessary)
4. [Any other supporting documentation]

Please process this claim at your earliest convenience. If you have any questions or need further information, feel free to contact me at [your phone number] or [your email address].

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Signature (if sending a hard copy)]