[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]
Subject: Medical Claim Submission for [Patient's Name], Policy Number: [Policy Number]
Dear Claims Department,
I am writing to formally submit a medical claim for services rendered to [Patient's Full Name], who is covered under policy number [Policy Number]. The details of the treatment are as follows:
Patient Information:
- Patient Name: [Patient's Full Name]
- Date of Birth: [Patient's Date of Birth]
- Policy Number: [Policy Number]
- Claim Number (if applicable): [Claim Number]
Provider Information:
- Provider Name: [Provider's Name]
- Provider NPI: [Provider's NPI Number]
- Facility Name: [Facility Name]
- Facility Address: [Facility Address]
- Phone Number: [Provider's Phone Number]
Service Information:
- Date of Service: [Date of Treatment]
- Type of Service: [Description of Services/Procedure]
- CPT Code(s): [CPT Codes]
- ICD-10 Code(s): [ICD-10 Codes]
- Total Charges: [$Amount]
Enclosed with this letter are the following supporting documents:
1. Itemized bill from the provider
2. Explanation of Benefits (EOB) from previous claims (if applicable)
3. Medical records (if required)
4. Any additional relevant documentation
Please process this claim at your earliest convenience. Should you need any further information or clarification regarding this submission, feel free to contact me at the phone number or email address listed above.
Thank you for your attention to this matter.
Sincerely,
[Your Signature (if sending a hard copy)]
[Your Printed Name]
[Your Relation to Patient (if applicable)]
[Enclosures: Itemized Bill, EOB, Medical Records, etc.]