[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 - [Claim Number if applicable]

Dear Claims Department,

I am writing to formally submit a medical claim for services received on [Date of Service] at [Provider's Name/Facility Name].

Details of the Claim:

- Patient Name: [Patient's Full Name]
- Policy Number: [Your Policy Number]
- Date of Service: [Date]
- Description of Services: [Brief description of the treatment/procedure]
- Total Amount Charged: [Total amount]
- Attachments: [List documents attached, e.g., bills, receipts, medical records]

I kindly request that the claim be processed in accordance with my policy terms. Should you need any further information, please do not hesitate to contact me.

Thank you for your attention to this matter.

Sincerely,

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