[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
Dear Claims Department,
I am writing to submit a medical claim for the treatment I received on [date of service] for [brief description of diagnosis/treatment]. Please find the relevant details below:
Patient Information:
- Patient Name: [Patient's Full Name]
- Policy Number: [Insurance Policy Number]
- Date of Birth: [Patient's Date of Birth]
Provider Information:
- Provider Name: [Healthcare Provider's Name]
- Provider Address: [Healthcare Provider's Address]
- Provider Phone: [Healthcare Provider's Phone Number]
Details of Claim:
- Date of Service: [Date]
- Description of Service: [Service Rendered]
- Total Amount Billed: [$Amount]
- Amount Covered by Insurance: [$Amount] (If known)
Enclosed you will find the following documents to support my claim:
1. Itemized bill from the provider
2. Proof of payment (if applicable)
3. Medical records (if necessary)
4. Claim form (if required by your policy)
I kindly request you to process my claim as soon as possible. Should you require any further information, please do not hesitate 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]
[Your Relationship to the Patient, if applicable]