[Your Practice or Hospital Letterhead]
[Date]
[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]
Re: Verification of Diagnosis Codes
Patient: [Patient's Full Name]
Date of Birth: [Patient's DOB]
Account Number: [Account Number]
Policy Number: [Policy Number]
Dear [Insurance Company Contact/ Department],
We are writing to verify the diagnosis codes associated with the above-referenced patient. The following codes have been documented in the patient's medical records:
1. **Primary Diagnosis:** [ICD-10 Code] - [Description]
2. **Secondary Diagnosis:** [ICD-10 Code] - [Description]
3. **Additional Diagnosis:** [ICD-10 Code] - [Description]
Please let us know if you require any additional information or documentation to process any claims related to these diagnoses.
Thank you for your attention to this matter.
Sincerely,
[Your Name]
[Your Title]
[Practice or Hospital Name]
[Phone Number]
[Email Address]