

[Your Name]
[Your Address]
[City, State, ZIP Code]
[Email Address]
[Phone Number]
[Date]

Kaiser Permanente Claims Department
[Address of the Claims Department]
[City, State, ZIP Code]

Subject: Insurance Claim Submission

Dear Claims Department,

I am writing to formally submit a claim for reimbursement related to my recent medical treatment received on [Date of Treatment] at [Provider's Name or Facility]. My member ID is [Your Member ID Number].

The details of the treatment are as follows:

- Type of Treatment: [e.g., consultation, surgery, etc.]
- Provider Name: [Provider's Name]
- Service Date: [Date of Service]
- Claim Amount: [Amount Charged]

I have attached copies of all relevant documents, including:

1. The itemized bill from the provider
2. The explanation of benefits (if applicable)
3. Any additional supporting documentation

Please process this claim and let me know if any further information is needed. I appreciate your assistance and prompt attention to this matter.

Thank you.

Sincerely,

[Your Name]
[Your Member ID Number]