[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Claims Department]
[Insurance Company Address]
[City, State, Zip Code]
Subject: Medical Reimbursement Application
Dear [Claims Adjuster's Name],
I am writing to formally request reimbursement for medical expenses incurred on [date(s) of service]. Below are the details of my claim:
Patient Information:
- Patient Name: [Your Name]
- Policy Number: [Your Policy Number]
- Claim Number: [If applicable]
Medical Service Details:
- Date of Service: [Date]
- Provider's Name: [Doctor/Hospital Name]
- Description of Service: [Brief description of the treatment or procedure]
- Total Amount Billed: [$ Amount]
- Amount Paid by Me: [$ Amount]
Attached Documents:
1. Itemized medical bill
2. Proof of payment (receipt)
3. Any other supporting documents (e.g., referral, prescription)
I kindly request you to process this application for reimbursement at your earliest convenience. Should you require any additional information or documentation, please do not hesitate to contact me.
Thank you for your attention to this matter.
Sincerely,
[Your Name]
[Your Signature (if sending a hard copy)]