

[Your Name]  
[Your Address]  
[City, State, Zip Code]  
[Email Address]  
[Phone Number]  
[Date]  
[Insurance Company Name]  
[Claim Department Address]  
[City, State, Zip Code]  
Subject: Health Insurance Claim Submission - [Policy Number/Claim Number]  
Dear Claims Department,  
I am writing to formally submit a claim for health insurance coverage under my policy number [Your Policy Number]. The details of the claim are as follows:  
\*\*Patient Information:\*\*  
Name: [Patient's Name]  
Date of Birth: [Patient's Date of Birth]  
Policy Number: [Your Policy Number]  
\*\*Provider Information:\*\*  
Provider Name: [Provider's Name]  
Facility Name: [Facility's Name]  
Facility Address: [Facility's Address]  
\*\*Claim Details:\*\*  
Date of Service: [Date of Service]  
Type of Service: [Description of Service]  
Total Amount Billed: [Total Amount]  
Diagnosis: [Diagnosis or Procedure Code]  
Enclosed are 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)  
Please process this claim at your earliest convenience. I appreciate your prompt attention to this matter and look forward to your response.  
Thank you for your assistance.  
Sincerely,  
[Your Signature (if sending a hard copy)]  
[Your Printed Name]  
[Your Policy Number]