[Your Name]
[Your Title/Position]
[Your Organization/Practice Name]
[Your Address]
[City, State, ZIP Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Claims Department Address]
[City, State, ZIP Code]
Subject: Request for Rx Reimbursement for [Patient's Name]
Dear Claims Department,
I am writing to request reimbursement for prescription medication on behalf of my patient, [Patient's Name], who is a member of your insurance plan (Member ID: [Patient's ID Number]).
**Prescription Details:**
- Medication Name: [Medication Name]
- Dosage: [Dosage]
- Quantity: [Quantity]
- Date of Prescription: [Prescription Date]
- Pharmacy Name: [Pharmacy Name]
- Total Cost: [Total Amount]
- Date of Service: [Date the medication was filled]
The medication was prescribed to [Patient's Name] for the treatment of [Condition/Diagnosis]. Attached, please find the following documents for your review:
1. Copy of the original prescription
2. Receipt from the pharmacy
3. Medical records supporting the need for the medication (if applicable)
Please process this request for reimbursement at your earliest convenience. If you require any additional information or documentation, do not hesitate to contact me at the phone number or email address listed above.
Thank you for your attention to this matter.
Sincerely,
[Your Signature (if sending a hard copy)]
[Your Printed Name]
[Your Title/Position]
[Your Organization/Practice Name]