[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]
Subject: Benefits Verification for Xtandi
Dear [Insurance Representative's Name],
I am writing to request a benefits verification for the medication Xtandi (enzalutamide) for my [patient's name], who has been diagnosed with [patient's condition].
Patient Information:
- Patient Name: [Patient's Full Name]
- Patient Date of Birth: [Patient's DOB]
- Insurance Policy Number: [Patient's Policy Number]
- Group Number: [Patient's Group Number] (if applicable)
Prescribing Physician:
- Physician Name: [Physician's Full Name]
- Physician NPI Number: [Physician's NPI Number]
- Physician Phone Number: [Physician's Phone Number]
Requested Information:
- Coverage status for Xtandi
- Prior authorization requirements
- Cost-sharing details (copays, deductibles)
Please provide this information at your earliest convenience, as it is crucial for the timely treatment of [patient's name]. Should you require any additional information, feel free to contact me at [your phone number] or [your email address].
Thank you for your attention to this matter.
Sincerely,
[Your Name]
[Your Title/Relationship to Patient]
[Your Organization Name] (if applicable)
[Your Organization Address] (if applicable)