[Your Hospital/Clinic Letterhead]
[Date]
[Recipient's Name]
[Recipient's Title]
[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]
Dear [Recipient's Name],
Subject: Request for QHS Reimbursement for [Patient's Name] - Claim #[Claim Number]
Patient Information:
- Patient Name: [Patient's Name]
- Date of Birth: [Patient's DOB]
- Policy Number: [Policy Number]
- Claim Number: [Claim Number]
- Date of Service: [Date of Service]
Details of Service Provided:
- Description of Service: [Brief description of QHS services provided]
- Total Charge: [Amount]
- Amount Paid by Patient: [Amount]
Rationale for Reimbursement:
[Explain the medical necessity and relevance of the QHS service provided, including any supporting documentation or codes.]
Attachments:
1. Copy of the Claim Form
2. Itemized Bill
3. Supporting Medical Records
4. Previous Correspondence (if applicable)
We kindly request the re-evaluation of this claim for reimbursement due to the reasons outlined above. Should you require any additional information or clarification, please do not hesitate to contact us at [Your Phone Number] or [Your Email Address].
Thank you for your attention to this matter.
Sincerely,
[Your Name]
[Your Title]
[Your Hospital/Clinic Name]
[Your Contact Information]