

[Your Name/Organization Name]  
[Your Address]  
[City, State, Zip Code]  
[Phone Number]  
[Date]

[Recipient Name/Department]  
[Insurance Company or Hospital Name]  
[Recipient Address]  
[City, State, Zip Code]

**RE: Enclosed Supporting Clinical Documentation**

Patient Name: [Patient Full Name]  
Date of Birth: [MM/DD/YYYY]  
Policy/Claim Number: [Number]  
Date of Service: [Date]

To Whom It May Concern,

Please find enclosed the supporting clinical documentation regarding the medical services provided to the above-referenced patient. This information is being submitted to facilitate the review of the [Claim/Prior Authorization/Appeal] currently on file.

The enclosed records include:

- [Item 1: e.g., Physician Consultation Notes]
- [Item 2: e.g., Laboratory and Diagnostic Results]
- [Item 3: e.g., Operative Report or Discharge Summary]
- [Item 4: e.g., Letter of Medical Necessity]

These documents provide clinical evidence to support the medical necessity of the treatment rendered. We request that you review this information and update the status of the file accordingly.

If you require any further information or have questions regarding these records, please contact our office at [Phone Number].

Sincerely,

[Signature]  
[Printed Name]  
[Title/Credentials]

Enclosure: [Total Number of Pages]