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

[Health Insurance Provider Name]
[Claims Department Address]
[City, State, Zip Code]

RE: Health Insurance Claim Submission / Appeal
Policyholder Name: [Name]
Policy/Member ID Number: [ID Number]
Group Number: [Group Number]
Claim Number (if applicable): [Claim Number]

To Whom It May Concern,

I am writing to formally [submit a new claim / appeal a denied claim] for medical services received on [Date of Service] at [Provider/Facility Name].

Enclosed with this letter, please find the following supporting documentation:

- Itemized billing statement
- Proof of payment
- Medical necessity letter from physician
- [List any other relevant documents]

Please review these documents and process the reimbursement as per my policy coverage. If you require any additional information, please contact me at [Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]