```
<p>
  [Your Name]<br>
  [Your Address]<br>
  [Your Phone Number]<br>
  [Your Email Address]<br>
  [Date]
</p>
<p>
  [Health Insurance Company Name]<br>
  [Claims/Appeals Department Address]<br>
  [City, State, Zip Code]
</p>
<p>
  <strong>RE: [Patient Name]</strong><br>
  <strong>Policy Number: [Your Policy Number]</strong><br>
  <strong>Group Number: [Your Group Number]</strong><br>
  <strong>Claim Number: [Claim Number (if applicable)]</strong>
</p>
<p>Dear Claims Department,</p>
<p>[Insert your message here, such as a request for claim reimbursement,
an appeal for a denied service, or an inquiry regarding coverage.]</p>
<p>
  Thank you for your time and assistance.<br>
  Sincerely,
</p>
<p>
  [Your Signature]<br>
  [Your Printed Name]
</p>
```