

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

[Recipient Name/Department]  
[Insurance Company or Provider Name]  
[Street 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]

To Whom It May Concern,

Please find enclosed the clinical documentation and medical records requested regarding the patient referenced above. These records are being provided to support [mention purpose, e.g., a pending claim, prior authorization request, or medical necessity review] for services dated [Service Dates].

The enclosed documentation includes:

- [Item 1: e.g., Diagnostic test results]
- [Item 2: e.g., Physician progress notes]
- [Item 3: e.g., Discharge summary]
- [Item 4: e.g., Operative reports]

Please review these materials and update the file accordingly. If additional information is required to finalize your review, please contact our office at [Phone Number] or via email at [Email Address].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]  
[Your Printed Name]  
[Your Title/Role]

Enclosures: [Number of pages or documents]