

[Your Name/Organization Name]
[Address Line 1]
[Address Line 2]
[Phone Number]
[Date]

[Recipient Name/Department]
[Insurance Company or Facility Name]
[Address Line 1]
[Address Line 2]

RE: Enclosed Supporting Clinical Documentation

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID/Claim Number: [ID Number]
Date of Service: [Date]

To Whom It May Concern,

Please find enclosed the clinical documentation requested to support the [Claim/Prior Authorization/Appeal] for the above-referenced patient.

The attached records include:

- [Item 1: e.g., Physician Progress Notes]
- [Item 2: e.g., Laboratory/Imaging Results]
- [Item 3: e.g., Plan of Care]

These documents provide clinical evidence of medical necessity for the services provided. If you require any further information to complete your review, please contact our office at [Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title]

Enclosure: [Number of Pages/Documents attached]