[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

Subject: Request for Coordination of Benefits (COB) Information

Dear [Patient Name],

We are contacting you regarding your recent medical services at [Provider/Facility Name].

While processing your insurance claim, your insurance carrier, [Insurance Company Name], indicated that they require updated Coordination of Benefits (COB) information to process your payment. This typically occurs when an insurance company needs to confirm if you have any other active health insurance coverage.

Action Required:

Please contact your insurance provider immediately to update your COB status. You can usually do this by:

- Calling the Member Services phone number on the back of your insurance card.
- Logging into your insurance provider's online member portal.
- Completing and returning any COB forms recently mailed to you by your insurer.

Please note that until this information is updated with your insurance company, they will not pay your pending claims. This may result in the full balance of [Amount, if known] becoming your personal responsibility.

Once you have updated this information, please notify our billing office at [Phone Number] so that we may resubmit your claim.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name/Department]
[Provider/Facility Name]
[Phone Number]