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

[Date]

[Insurance Company Name]
[COB Department Address]
[City, State, Zip Code]

RE: Coordination of Benefits Verification

To Whom It May Concern,

I am writing to update/verify my Coordination of Benefits (COB) information regarding my Medicare coverage and my supplemental/secondary insurance policy.

Please update your records with the following information:

- **Medicare Part A Effective Date:** [Date]
- **Medicare Part B Effective Date:** [Date]
- **Primary Insurance:** [Name of Primary Plan]
- **Secondary Insurance:** [Name of Secondary Plan]
- **Policy/Group Number:** [Number]

I am notifying you that (select one):
[ ] Medicare is my primary payer.
[ ] My group health plan is my primary payer.

This coordination is necessary to ensure that my medical claims are processed correctly and without delay. Please confirm once your records have been updated. If you require additional documentation, such as a copy of my Medicare card or other insurance ID, please let me know.

Thank you for your assistance.

Sincerely,

[Your Signature]

[Your Printed Name]