[Date]

[Payer Name]
[Claims Department Address]
[City, State, Zip Code]

RE: Coordination of Benefits Inquiry

Patient Name: [Patient Name]
Member ID: [Member ID]
Group Number: [Group Number]
Date of Birth: [DOB]
Claim Number: [Claim Number (if applicable)]
Date of Service: [Date of Service]

Dear Claims Department,

We are writing to request a formal update regarding the Coordination of Benefits (COB) status for the above-referenced patient. Our records indicate that the claim(s) submitted for the services provided on [Date of Service] are currently being delayed or have been denied pending COB verification.

Please review your records to determine if this patient has other primary insurance coverage or if [Payer Name] is the primary carrier. If additional information is required from the member to update their file, please notify us or the member immediately to prevent further processing delays.

If you have already received the necessary COB information, please reprocess the affected claim(s) for payment. Attached, you will find [List any attachments, e.g., a copy of the claim or primary EOB].

Thank you for your prompt attention to this matter. If you have any questions, please contact our billing department at [Phone Number].

Sincerely,

[Your Name/Department]
[Provider/Facility Name]
[Tax ID Number]