[Date]

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

Subject: Welcome and Coordination of Benefits (COB) Information

Dear [Patient Name],

Welcome to [Practice/Clinic Name]. We are pleased to have you as a new patient and look forward to providing you with quality healthcare services.

To ensure that your insurance claims are processed accurately and to minimize your out-of-pocket expenses, we need to verify your **Coordination of Benefits (COB)**. This process determines which insurance company pays first when a patient is covered by more than one health plan.

Please provide the following information regarding your coverage:

- Primary Insurance Provider and Policy Number
- Secondary Insurance Provider and Policy Number (if applicable)
- Name of the primary policyholder for each plan
- Relationship to the policyholder

It is important to contact your insurance providers directly to update your COB status. If your insurance company does not have the correct information on file, they may deny your claims, which could result in the full balance becoming your responsibility.

Please bring your current insurance cards and a valid photo ID to your first appointment on [Appointment Date].

If you have any questions, please contact our billing department at [Phone Number] or [Email Address].

Sincerely,

[Your Name/Department]
[Practice/Clinic Name]
[Phone Number]