[Date]

[Member Name]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]

RE: Request for Missing Coordination of Benefits (COB) Information

Member ID: [Member ID Number]

Claim Number: [Claim Number (if applicable)]

Dear [Member Name],

We are writing to inform you that we cannot process your recent medical claim(s) because we do not have current information regarding other health insurance coverage you or your dependents may have.

To ensure your claims are paid accurately and timely, please provide the following information:

- Are you or any family members covered by another health insurance plan (including Medicare)? [Yes / No]
- If yes, please provide the Name of the Insurance Carrier: [Carrier Name]
- Policyholder Name and Date of Birth: [Name/DOB]
- Policy/ID Number: [Policy Number]
- Effective Date of Coverage: [Date]

You can provide this information by:

- **Phone:** Call our Member Services Department at [Phone Number].
- **Mail:** Complete this form and return it to [Mailing Address].
- **Online:** Log in to your member portal at [Website URL] and update your profile.

Please submit this information by [Due Date]. Failure to respond may result in the denial of your claims, making you responsible for the full cost of services rendered.

Thank you for your prompt attention to this matter.

Sincerely,

[Sender Name/Department]
[Company Name]