[Your Name/Company Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Insurance Carrier Name]
[Claims Department]
[Address]
[City, State, Zip Code]

RE: Coordination of Benefits Inquiry

Claimant Name: [Employee Full Name]
Claim Number: [Claim Number]
Date of Injury: [MM/DD/YYYY]
Social Security Number (Last 4): [XXXX]

To Whom It May Concern,

We are writing to request a formal coordination of benefits review regarding the above-referenced workers' compensation claim. Our records indicate that the claimant may be eligible for or currently receiving concurrent benefits from another source.

Please provide information regarding any offsets or supplemental payments related to the following:

- Social Security Disability Insurance (SSDI)
- Private Disability Insurance (Short-Term or Long-Term)
- Employer-sponsored pension or retirement plans
- Medicare/Medicaid eligibility
- Third-party liability settlements

Kindly confirm the current benefit rate being paid, the effective date of these benefits, and whether any adjustments have been made to account for overlapping coverage. If a credit or lien is being asserted, please provide an itemized statement of the amounts in question.

Please submit the requested documentation to our office within [Number] business days. Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]
[Your Title]