[Your Name/Practice Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

RE: Submission of Diagnostic Imaging Records

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member/Policy ID: [ID Number]
Claim/Reference Number: [Claim Number, if applicable]
Date of Service: [Date Image was Taken]

To Whom It May Concern,

Please find enclosed the diagnostic imaging records requested for the above-referenced patient and claim. These records are being provided to assist in the medical necessity review or claims processing for the services rendered.

The enclosed documentation includes:

- [Type of Image: e.g., MRI/CT/X-Ray] Radiology Report
- [Optional: CD/Digital Link containing DICOM images]
- [Optional: Clinical notes justifying the scan]

If you require any additional information or have further questions regarding these records, please contact our office directly at [Phone Number].

Sincerely,

[Your Signature/Name]
[Your Title/Role]

Enclosures: [List Number of Documents]