[Date]

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

RE: Insurance Verification for Chronic Disease Management

Patient Name: [Patient Full Name]
Policy Number: [Policy Number]
Group Number: [Group Number]
Date of Birth: [Patient Date of Birth]

To Whom It May Concern,

I am writing to verify the insurance coverage and benefits for [Patient Name], who is currently under my care for the management of the following chronic condition(s): [List Chronic Condition, e.g., Type 2 Diabetes, Hypertension, COPD].

Effective management of this condition requires ongoing services. Please provide confirmation of coverage for the following:

- Chronic Care Management (CCM) services (CPT Codes: [e.g., 99490, 99439])
- Frequency of allowed office visits per calendar year
- Diagnostic testing and laboratory work related to this condition
- Prescription medication coverage for [Name of Medication, if applicable]
- Requirements for prior authorization or referrals

Please clarify the patient's financial responsibility, including co-payments, co-insurance, and any remaining deductible for the current benefit period.

Attached is a summary of the medical necessity for these services. If further documentation is required, please contact my office at [Phone Number].

Thank you for your prompt assistance.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Practice Name]
[NPI Number]