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

[Date]

[Recipient Name/Adjuster Name]
[Company/Insurance Name]
[Address]
[City, State, Zip Code]

RE: Medical Evidence and Billing Documentation

Patient Name: [Patient Full Name]
Claim Number: [Claim Number]
Date of Birth: [DOB]
Date of Incident: [Date]

Dear [Recipient Name],

Please find enclosed the requested medical evidence and corresponding billing statements regarding the above-referenced individual and claim.

The enclosed documentation includes:

- Certified Medical Records from [Facility/Provider Name]
- Diagnostic Imaging Reports (dated [Date])
- Treatment Summaries and Progress Notes
- Itemized Billing Statements
- [Additional Document Name]

The total amount of medical expenses incurred to date, as reflected in the attached billing, is $[Total Amount]. These records are being provided to support the ongoing evaluation of the claim and to verify the necessity and costs of the treatment received.

Should you require any additional information or further clarification regarding these documents, please contact my office directly at [Your Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title]

Enclosures: [List Number of Pages or Documents]