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

[Date]

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

RE: Health Insurance Claim Submission
Policy Number: [Your Policy Number]
Group Number: [Your Group Number]
Claim Reference Number: [If applicable]

Dear Claims Department,

I am writing to formally submit a claim for medical services received on [Date of Service]. I request that you process this claim in accordance with the coverage terms of my health insurance policy.

Patient Information:
Name: [Patient Name]
Relationship to Policyholder: [Self/Spouse/Dependent]
Date of Birth: [MM/DD/YYYY]

Provider Information:
Provider Name: [Doctor or Facility Name]
NPI Number: [Provider NPI Number, if known]
Address: [Provider Address]

Service Details:
Description of Services: [Briefly describe the treatment or procedure]
Total Amount Billed: $[Amount]

Please find the following documents attached to support this claim:

- Completed Claim Form
- Itemized Medical Bill (HCFA-1500 or UB-04 form)
- Proof of Payment (if reimbursement is requested)
- Referral or Pre-authorization Letter (if applicable)

Please direct all correspondence regarding this claim to my address listed above. If any additional information is required to process this request, please contact me via phone or email.

I look forward to receiving the Explanation of Benefits (EOB) and confirmation of payment within the timeframe required by state regulations.

Sincerely,

[Your Signature]

[Your Printed Name]