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

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

Subject: Verification of Health Insurance Benefits and Eligibility

To Whom It May Concern,

I am writing to formally request a verification of benefits and eligibility for the following member:

- **Member Name:** [Full Name]
- **Member ID Number:** [ID Number]
- **Group Number:** [Group Number]
- **Date of Birth:** [MM/DD/YYYY]

Please provide written confirmation regarding the following details for the current plan year:

1. Current enrollment status and effective date of coverage.
2. Specific coverage details for [Insert Type of Service, e.g., Mental Health, Physical Therapy].
3. Individual and family deductible amounts (met and remaining).
4. Out-of-pocket maximums (met and remaining).
5. Co-payment or co-insurance requirements for in-network and out-of-network providers.
6. Whether prior authorization is required for the aforementioned services.

Please send the requested information to the address listed above or via fax at [Fax Number]. If you require additional information, I can be reached at [Phone Number] or [Email Address].

Thank you for your prompt attention to this matter.

Sincerely,

[Signature]
[Printed Name]