Sample Benefits Verification Provider Request Letter

Date:

Provider Name

Provider Address

Provider City, Zip, State

Re: Benefit Verification for Medication

 Patient Name:

 Patient Health Plan ID #:

 Patient Birthdate:

Dear Dr. [NAME],

I have changed my [insurance plan or medication] and want to initiate the benefits verification process that might be necessary for the new plan year.

The plan policies that will affect my access include [outline the relevant policies from benefits booklet. Categories below are examples]

* Prior Authorization

Include policy details here

* Step Therapy

Include policy details here

* Specialty Pharmacy

Include policy details here

* Mail Order

Include policy details here

I appreciate your prompt attention to this request in order to avoid any lapses in my medication access.

Please let me know if you need additional information in order to get this process completed. I can be reached at xxx-xxx-xxxx (phone) or janedoe@email.com.

Sincerely,

[NAME]