Out of Network Insurance Reimbursement Request

Services rendered at the office of
Asim Guha Roy, MD, Inc.
4540 Kearny Villa Road Suite 106
San Diego, CA 92123
Tax ID: 52-2355008

Patient's Information

Last Name: ____________________________ First Name: ____________________________

DOB: __________________________________ SSN#: __________________________________

Address: ____

Insurance ID Number: ____
(this number is located on the front of your insurance card, may also be called "member id")

Relationship to Subscriber: _______________________ (self, spouse, child, domestic partner, legal guardian)

Date of Service: ____
(when was your appointment with Dr. Guha Roy)

Subscriber's Information (who is the policy holder for the insurance)

Last Name: ____________________________ First Name: ____________________________

DOB: __________________________________ SSN#: __________________________________

To whom it may concern,
Please accept this letter as a request for reimbursement for services received at the office of Asim Guha Roy, MD, an out of network provider.

Included with this letter, you will find:

A copy of my latest medical insurance card.

A list of services I received with the appropriate CPT codes for those services.

A record of the medical diagnoses for which the services were rendered.

A copy of the receipt showing payment for services rendered to Dr. Asim Guha Roy's office.

Thank you for your prompt attention to this matter. Should you have any questions, please feel free to contact me at ___________________ or _______________________.
(Phone number) (Email address)

Regards,

***X*____________________________
(your signature)