

Date

ABC Insurance Company
123 Main Street
Anytown, USA 12345

Predetermination of benefits for: (patient's name)
Group/group number: (name of group and number, if applicable)
ID Number: (patient's insurance identification number)

Dear (Insurance company contact's name):

My wife (or husband) and I are considering (In-vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, or other procedure Dr. Cowart has recommended). This procedure is necessary to attempt pregnancy due to (explain your situation, e.g., blocked fallopian tubes, male factor, previous sterilization, unexplained infertility, etc.). A fee schedule from our physician is attached for your review.

Please provide me with a written response to each of the questions below:

1. Will (the procedure that applies to your situation) be a payable procedure under my current coverage?
2. If yes, is there a limit of any kind (dollars or number of attempts)?
3. If no, are any portions of the charges payable (prescription medications, laboratory tests, ultrasounds, or any other components Dr. Cowart has identified)?
4. If none of the charges are payable, please identify the page in my contract where all the charges are specifically excluded and the date the exclusion was added to the contract. If the charges are not excluded, I will assume they are payable.

I would appreciate a response as soon as possible. Thank you.

Sincerely,

(Your Signature)