



DATE: ____/____/____

PATIENT:	_____	GROUP NO:	_____
EMPLOYEE:	_____	ACCT NO:	_____
CLAIM NO:	_____	INCURRED:	_____
PROVIDER:	_____	CHARGE:\$	_____

RE: Request for Primary/Secondary Explanation of Benefits

To Whom It May Concern:

We have received a claim for the patient named above. In order to complete the processing of this claim, we require a copy of the corresponding Explanation of Benefits (EOB) from the patient's primary insurance carrier.

The requested information must be received by HealthComp within forty-five (45) days from the date of the initial request or the claim will be denied/closed.

If you have any questions, please contact our office at (800) 442-7247.

Sincerely,

HealthComp Administrators
Claims Department