

*(Date)*

*(Insurance Company)*

*(Address)*

*(City, State, Zipcode)*

Re: Predetermination of benefits

*(Patient Name)*

*(Insurance ID #)*

*(Insurance Group #)*

To Whom It May Concern:

I am writing to inquire about the fertility benefits provided under my policy. Please provide a written response to the following questions:

1. Does my policy provide for infertility benefits?
2. Do I have diagnostic infertility coverage allowing me to receive services to find the cause of my infertility?
3. Do I have artificial insemination coverage?
4. Do I have treatment coverage for in vitro fertilization? Does this include cryopreservation, intracytoplasmic sperm injection, and/or frozen embryo transfer?
5. What is my maximum Infertility benefit?
6. Are medications covered?

Sincerely,

*(Patient Name)*