Pre-Authorization Request for Diagnostic Tests

Date: [Insert Date]

To: [Insurance Company Name]

Address: [Insurance Company Address]

Policy Number: [Insert Policy Number]

Dear [Insurance Representative's Name],

I am writing to request pre-authorization for diagnostic tests for my patient, [Patient's Name], who has been under my care for [duration of treatment].

Patient Information:

- Name: [Patient's Full Name]
- Date of Birth: [Patient's Date of Birth]
- Policy Number: [Patient's Policy Number]
- Group Number: [Patient's Group Number]

Requested Tests:

- [Test Name 1]
- [Test Name 2]
- [Test Name 3]

Medical Necessity:

[Briefly explain the medical necessity for the requested tests and any relevant ICD codes.]

Please find attached supporting documentation, including the patient's medical history and notes regarding the need for these diagnostic tests.

Thank you for your attention to this matter. I look forward to your prompt response to this pre-authorization request.

Sincerely,

[Your Name]
[Your Title]
[Your Medical Practice Name]

[Your Address]
[Your Phone Number]
[Your Email]