Health Insurance Pre-Authorization Request

Date: [Insert Date]

To: [Insurance Company Name]

Address: [Insurance Company Address]

Re: Pre-Authorization Request for Medication

Dear [Insurance Company Representative's Name],

I am writing to request pre-authorization for the medication **[Medication Name]** for my patient, **[Patient's Name]**, who is a member of your health plan (Policy Number: [Policy Number]).

The patient has been diagnosed with **[Diagnosis]** and has been prescribed **[Medication Name]** by their physician, Dr. **[Physician's Name]**. This medication is essential for managing their condition effectively.

Attached are the necessary documents, including the physician's prescription, medical records, and supporting clinical information, which justify the need for this medication.

Please process this pre-authorization request at your earliest convenience. If you require any further information, do not hesitate to contact me at **[Your Phone Number]** or **[Your Email Address]**.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name]
[Your Title]
[Your Organization]
[Your Contact Information]