Health Insurance Pre-Authorization Request

Date: [Insert Date]

To: [Insurance Company's Name]

Address: [Insurance Company's Address]

Policyholder Name: [Insert Name]

Policy Number: [Insert Policy Number]

Claim Number: [Insert Claim Number]

Patient Name: [Insert Patient Name]

Patient Date of Birth: [Insert DOB]

Out-of-Network Provider Name: [Insert Provider's Name]

Provider's Address: [Insert Provider's Address]

Requested Services: [List of Services Requested]

Reason for Out-of-Network Request:

[Provide a detailed explanation of why out-of-network services are necessary]

Attached Documents:

- [Insert relevant documents, such as medical records, referral letters, etc.]

I appreciate your prompt attention to this matter and look forward to your approval of the necessary services.

Thank you,

[Your Name]

[Your Contact Information]