Pre-Authorization Request for Specialized Treatment

Date: **[Insert Date]**

To: **[Insurance Company Name]**

Attn: Pre-Authorization Department

Policy Number: **[Insert Policy Number]**

Claim Number: **[Insert Claim Number]**

Dear [Insurance Company Representative's Name],

I am writing to formally request pre-authorization for specialized treatment for my patient, [Patient's Name], who has been diagnosed with [Diagnosis]. This treatment is essential for the management of the patient's condition and has been recommended by [Doctor's Name], [Doctor's Title/Position].

Details of the Treatment:

- **Type of Treatment:** [Type of Treatment]
- **Provider's Name:** [Provider's Name]
- **Provider's Contact Information:** [Provider's Contact Information]
- **Proposed Start Date:** [Proposed Date]

Attached are the relevant medical records, test results, and letters of medical necessity to support this request. The treatment outlined is critical for [Patient's Name]'s health and well-being.

Please feel free to contact me at [Your Phone Number] or [Your Email] if you require any further information or documentation.

Thank you for your attention to this urgent matter. I look forward to your prompt response.

Sincerely,

[Your Name]
[Your Title/Position]
[Your Practice Name]
[Your Contact Information]