Pre-Authorization Request for Surgery

Date: [Insert Date]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Re: Pre-Authorization Request for [Patient's Name]

Policy Number: [Insert Policy Number]

Patient's Date of Birth: [Insert DOB]

Claim Number (if applicable): [Insert Claim Number]

Dear [Insurance Company Representative/Department],

I am writing to request pre-authorization for a surgical procedure for my patient, [Patient's Name], scheduled for [Insert Date]. This procedure is necessary due to [Briefly Explain Medical Condition and Reason for Surgery].

The details of the procedure are as follows:

- Procedure Name: [Insert Procedure Name]
- Date of Surgery: [Insert Date]
- Provider Name: [Insert Surgeon's Name]
- Facility Name: [Insert Hospital/Facility Name]

Attached are the relevant medical records and documentation to support this request, including:

- Physical Examination Results
- Imaging Reports
- Lab Test Results
- Physician's Recommendation

Thank you for your attention to this matter. Please let me know if you require any additional information to facilitate this request. I look forward to your prompt response.

Sincerely,

[Your Name]

[Your Title]

[Your Contact Information]

[Practice/Clinic Name]

[Practice/Clinic Address]