

# Pre-Authorization Request for Hospital Coverage

Date: [Insert Date]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

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

Policy Number: [Insert Policy Number]

Date of Birth: [Insert Patient's Date of Birth]

Dear [Insurance Company Representative's Name],

I am writing to request pre-authorization for hospital coverage for my patient, [Patient's Full Name], who requires [brief description of the medical procedure or treatment]. This procedure is necessary due to [provide brief medical justification].

The details of the procedure are as follows:

- Procedure: [Insert Procedure Name]
- Date of Service: [Insert Date or Date Range]
- Hospital/Facility Name: [Insert Hospital/Facility Name]
- Provider Name: [Insert Attending Physician's Name]
- Contact Number: [Insert Contact Number]

Please find attached relevant medical documentation that supports the need for this procedure.

Thank you for your prompt attention to this matter. Should you have any questions or require further information, please feel free to contact me at [Your Phone Number] or [Your Email Address].

Sincerely,

[Your Name]

[Your Title]

[Your Practice/Organization Name]

[Your Address]

[City, State, Zip Code]