Healthcare Treatment Authorization

Date: [Insert Date]

To: [Insurance Company Name]

Address: [Insurance Company Address]

Policy Number: [Insert Policy Number]

Claim Number: [Insert Claim Number]

Patient Name: [Insert Patient Name]

Patient Date of Birth: [Insert DOB]

Provider Name: [Insert Provider Name]

Provider Address: [Insert Provider Address]

Subject: Request for Treatment Authorization

Dear [Insurance Company Representative],

I am writing to request authorization for treatment for the above-named patient. The recommended treatment is deemed medically necessary and is outlined as follows:

- **Diagnosis:** [Insert Diagnosis]
- **Treatment Plan:** [Insert Treatment Details]
- **Expected Duration:** [Insert Duration]

Please find attached any relevant medical documentation and test results that support this request.

Thank you for your attention to this matter. Please do not hesitate to contact me at [Insert Provider Contact Information] for any further information.

Sincerely,

[Insert Your Name]
[Insert Your Title]
[Insert Provider Name]