Healthcare Treatment Authorization Request

To: [Insurance Company Name]

Address: [Insurance Company Address]

City, State, Zip Code: [City, State, Zip]

Patient Name: [Patient's Full Name]

Patient ID: [Patient ID Number]

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

Prescribing Physician: [Doctor's Full Name]

Phone Number: [Doctor's Phone Number]

Fax Number: [Doctor's Fax Number]

Dear [Insurance Company Name] Team,

I am writing to request authorization for prescription drug coverage for my patient, [Patient's Full Name], who has been diagnosed with [Diagnosis/Condition]. The prescribed medication is [Medication Name], and it has been deemed medically necessary for their treatment.

Details of the prescription are as follows:

- **Medication Name:** [Medication Name]
- **Dosage:** [Dosage]
- **Quantity:** [Quantity]
- **Directions:** [Directions for Use]

This medication is essential for [Patient's Name] to manage their condition effectively. Attached, you will find the relevant medical records and documentation supporting this request.

Please contact my office at [Doctor's Phone Number] or via fax at [Doctor's Fax Number] should you require any additional information.

Thank you for your prompt attention to this matter.

Sincerely,

[Doctor's Full Name]

[Doctor's Signature (if sending hard copy)]

[Medical Practice Name]

[Practice Address]

[City, State, Zip Code]