Request for Pre-Authorization

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]

Dear [Insurance Coordinator's Name or "To Whom It May Concern"],

I am writing to formally request pre-authorization for medical treatment for my patient, [Patient's Name], who has been diagnosed with [Diagnosis]. The specific treatment being requested is [Describe Treatment], which is scheduled for [Procedure Date].

Details of the requested treatment are as follows:

- Procedure: [Name of Procedure]
- Date of Service: [Insert Date]
- Provider's Name: [Provider's Name]
- Provider's Contact Information: [Provider's Phone/Email]

This treatment is medically necessary as [Brief Explanation of Medical Necessity]. Enclosed are the relevant medical records, including [List any attached documents], that support this request.

Please process this request at your earliest convenience, and do not hesitate to contact me at [Your Phone Number] or [Your Email] should you require any further information.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name]

[Your Title]

[Your Organization]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email]