Prior Authorization Request

Date: [Insert Date]

To: [Insurance Company Name]

Address: [Insurance Company Address]

Phone: [Insurance Company Phone Number]

From: [Your Name or Provider's Name]

Practice Name: [Provider's Practice Name]

Address: [Provider's Address]

Phone: [Provider's Phone Number]

Patient Information

Patient Name: [Patient's Name]

Date of Birth: [Patient's DOB]

Policy Number: [Patient's Policy Number]

Procedure Request

Procedure Name: [Name of the Procedure]

Procedure Code: [CPT/ICD Code]

Requested Date of Service: [Requested Date]

Medical Necessity

[Brief explanation of medical necessity for the procedure, including relevant patient history and supporting information.]

Attachments

[List of any attached documents such as clinical notes, previous test results, or other relevant information.]

Thank you for your prompt attention to this request. Please feel free to contact me at [Your Phone Number] or [Your Email] if you require any further information.

Sincerely,

[Your Name]
[Your Title]
[Provider's Practice Name]