Prior Authorization Request for Outpatient Surgery

To: [Insurance Company Name]

From: [Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

Date: [Date]

Policy Number: [Policy Number]

Member ID: [Member ID]

Patient Information

Patient Name: [Patient's Name]
Date of Birth: [Patient's DOB]
Diagnosis: [Diagnosis]

Procedure Details

Requested Procedure: [Procedure Name]
Procedure Date: [Planned Procedure Date]
Facility Name: [Facility Name]
Provider Name: [Provider Name]
Tax ID Number: [Provider Tax ID]

Clinical Justification

[Insert a brief clinical rationale for the requested procedure, including any relevant medical history or previous treatments.]

Attachment

Please find attached the necessary documentation, including:
- Medical records
- Referral letters
- Previous imaging results

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

Sincerely,
[Your Name]
[Your Title, if applicable]
[Practice/Facility Name]