Prior Authorization Request

To: [Insurance Company Name]

Address: [Insurance Company Address]

Date: [Current Date]

Patient Information

Patient Name: [Patient's Full Name]

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

Insurance ID: [Patient's Insurance ID]

Referring Physician

Physician Name: [Referring Physician's Full Name]

Practice Name: [Physician's Practice Name]

Contact Number: [Physician's Contact Number]

Request Details

Procedure Requested: [Name of Diagnostic Imaging Procedure]

ICD-10 Code: [Relevant ICD-10 Code]

Clinical Indication: [Reason for Imaging Request]

Supporting Information

Please find attached any relevant medical records and previous imaging results that support this request.

Authorization Request

We kindly request prior authorization for the specified diagnostic imaging as it is medically necessary for the evaluation and management of the patient's condition.

Contact Information

If you have any questions or require further information, please contact me at [Your Contact Information].

Sincerely,

[Your Name]
[Your Title]
[Your Practice Name]
[Your Contact Information]