# Prior Authorization Inquiry

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Your Phone Number]

[Your Email Address]

[Insurance Provider's Name]

[Insurance Provider's Address]

[City, State, Zip Code]

Dear [Insurance Provider's Contact Person],

I am writing to inquire about the prior authorization status for the physical therapy services recommended for [Patient's Name], [Patient's Insurance ID Number]. The services were requested on [Date of Request] and include [briefly describe the proposed services].

The treatment is necessary due to [Patient's Condition/Diagnosis] and has been prescribed by [Referring Physician's Name] on [Date of Prescription]. Please let me know if additional information is required to facilitate the review process.

I appreciate your prompt attention to this matter and look forward to your response.

Sincerely,

[Your Name]

[Your Title/Occupation]