Prior Authorization Request for Specialist Referral

Date: [Insert Date]

To: [Insurance Company Name]

From: [Your Name]

[Your Address]

[City, State, Zip Code]

Phone: [Your Phone Number]

Email: [Your Email Address]

Subject: Request for Prior Authorization for Specialist Referral

Dear [Insurance Company Contact/Department Name],

I am writing to request prior authorization for a referral to a specialist for [Patient's Name], who is a member of your insurance plan.

Patient Information:

- Name: [Patient's Full Name]
- Date of Birth: [Patient's Date of Birth]
- Insurance ID: [Patient's Insurance ID]

Referring Physician:

- Name: [Your Full Name]
- Practice Name: [Your Practice Name]
- Phone: [Your Phone Number]
- Fax: [Your Fax Number]

Specialist Information:

- Name: [Specialist's Full Name]
- Specialty: [Specialist's Specialty]
- Practice Name: [Specialist's Practice Name]

- Phone: [Specialist's Phone Number]

The reason for this referral is [Explain the medical necessity for the referral, including any relevant diagnoses, treatment history, and specific concerns].

Included with this request are relevant medical records and documents that support this referral.

Thank you for your prompt attention to this matter. Please contact me at [Your Phone Number] or [Your Email Address] if you require any additional information.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Title]