

Prior Authorization Request for Diagnostic Testing

Patient Name: [Patient's Full Name]

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

Insurance Provider: [Insurance Company Name]

Policy Number: [Patient's Policy Number]

Requesting Provider: [Provider's Name]

Provider Contact Information: [Phone Number, Fax Number]

Date: [Date]

To Whom It May Concern,

I am writing to request prior authorization for the following diagnostic test(s) for my patient:

- **Test Name:** [Name of Diagnostic Test]
- **ICD-10 Code:** [ICD-10 Code]
- **Reasons for Testing:** [Brief explanation of need for testing]

This test is medically necessary to evaluate and guide further treatment for [Patient's Condition]. Supporting documentation, including the patient's medical records, referral information, and relevant lab results, are enclosed.

Please contact me at [Provider's Phone Number] or [Provider's Email] should you require further information.

Thank you for your attention to this matter.

Sincerely,

[Provider's Name]

[Provider's Title]

[Provider's Practice Name]

[Provider's Address]

[Provider's Phone Number]

[Provider's Fax Number]