

# Prior Authorization Request for Durable Medical Equipment

**Your Name:** [Your Name]

**Your Address:** [Your Address]

**Your Phone Number:** [Your Phone Number]

**Your Insurance Information:** [Insurance Company Name, Policy Number]

**Date:** [Date]

## To Whom It May Concern,

I am writing to request prior authorization for durable medical equipment as prescribed by my physician, Dr. [Doctor's Name]. This equipment is deemed medically necessary to treat my condition of [Condition/Diagnosis].

### Details of Requested Equipment:

**Equipment Name:** [Name of Equipment]

**Manufacturer:** [Manufacturer Name]

**Model Number:** [Model Number]

**Prescription Date:** [Date of Prescription]

### Supporting Information:

Attached are relevant medical records and documentation supporting this request, including:

- Physician's letter
- Clinical notes
- Any other pertinent documentation

Please contact me at [Your Phone Number] or [Your Email Address] for any further information regarding this request.

Thank you for your assistance.

Sincerely,

[Your Name]