Prior Authorization Request

Date: [Insert Date]

To: [Insurance Company Name]

Address: [Insurance Company Address]

Attention: Prior Authorization Department

Re: Prior Authorization Request for Outpatient Procedure

Patient Name: [Patient Name]

Patient ID: [Patient ID]

Date of Birth: [Patient DOB]

Procedure Requested: [Name of Outpatient Procedure]

CPT Code: [CPT Code]

Requested Date of Procedure: [Requested Date]

Dear [Insurance Company Representative],

I am writing to request prior authorization for the above-listed outpatient procedure for my patient, [Patient Name]. This procedure is medically necessary due to [briefly explain the medical necessity and relevant medical history].

Attached are the required medical records and supporting documentation that outline the necessity of this procedure.

If you have any questions or require further information, please do not hesitate to contact me at [Your Phone Number] or [Your Email Address].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name]

[Your Title]

[Your Medical Practice Name]

[Your Address]

[Your Phone Number]

[Your Email Address]