Prior Authorization Request

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient ID: [Insert Patient ID]

Insurance Provider: [Insert Insurance Provider]

Policy Number: [Insert Policy Number]

Provider Name: [Insert Provider Name]

Provider NPI: [Insert Provider NPI]

Provider Phone Number: [Insert Provider Phone Number]

Provider Address: [Insert Provider Address]

Subject: Request for Prior Authorization for Rehabilitation Services

Dear [Insurance Provider's Name or Department],

I am writing to request prior authorization for rehabilitation services for my patient, [Insert Patient Name], who has a diagnosis of [Insert Diagnosis]. These services are medically necessary to aid in the recovery and rehabilitation process.

Request Details:

- Type of Service: [Insert Type of Rehabilitation Service]
- Start Date: [Insert Start Date]
- Expected Duration: [Insert Expected Duration]

The recommended rehabilitation services have been prescribed in accordance with [Insert Clinical Guidelines or Rationale]. Supporting documentation, including the patient's medical records, progress notes, and relevant diagnostic tests, is attached for your review.

Thank you for your attention to this matter. I look forward to your prompt response to this request. Please feel free to contact me at [Insert Your Phone Number] or [Insert Your Email Address] should you require any additional information.

Sincerely,

[Your Name]

[Your Title]

[Your Organization]

[Your Organization Address]