Prior Authorization Request for Surgery

Date: [Insert Date]

To: [Insurance Company Name]

Address: [Insurance Company Address]

Patient Name: [Patient's Full Name]

Patient ID: [Patient ID Number]

Procedure Requested: [Name of Surgery/Procedure]

Requested Date of Surgery: [Proposed Date]

Referring Physician: [Physician's Name]

Physician's Phone/Fax: [Physician's Contact Information]

Description of Medical Necessity:

[Detailed explanation of the medical necessity for the surgery, including any relevant clinical details or supporting information.]

Supporting Documentation:

- [List any attached documents, such as medical records, test results, etc.]

Signature:

[Physician's Name]

[Physician's Title]

[Practice Name]

[Practice Address]

[Practice Phone Number]