Medical Treatment Authorization Request

Date: [Insert Date]

To: [Insurance Company Name]

Address: [Insurance Company Address]

City, State, Zip: [Insurance Company City, State, Zip]

Dear [Insurance Representative's Name],

I am writing to request authorization for medical treatment for [Patient's Name], who is covered under policy number [Policy Number]. The requested treatment is [Specify Treatment], which is deemed necessary by [Physician's Name] due to [Brief Description of Medical Condition].

The details of the proposed treatment are as follows:

- **Type of Treatment:** [Specify Treatment]
- **Date of Service:** [Proposed Date]
- **Provider's Name:** [Provider's Name]
- **Provider's Contact Information:** [Provider's Contact Info]

Enclosed are the relevant medical records and notes from [Physician's Name] to support this request. Please review the information and grant authorization for this necessary treatment.

Thank you for your prompt attention to this matter. Should you require any further information, feel free to contact me at [Your Phone Number] or [Your Email Address].

Sincerely,

[Your Name]

[Your Address]

[City, State, Zip]

[Your Phone Number]

[Your Email Address]