Dental Insurance Prior Authorization Request

Date: [Insert Date]

To: [Insurance Company Name]

Attn: Prior Authorization Department

Address: [Insurance Company Address]

Policyholder Name: [Insert Policyholder's Name]

Policy Number: [Insert Policy Number]

Patient Name: [Insert Patient's Name]

Patient Date of Birth: [Insert Patient's Date of Birth]

Subject: Prior Authorization Request for Dental Procedure

Dear [Insurance Company Name],

I am writing to request prior authorization for dental procedure [Insert Procedure Name] for the patient mentioned above. This procedure is necessary for [brief description of medical necessity].

Please find the following information to support this request:

- **Procedure Code:** [Insert Procedure Code]
- **Diagnosis Code:** [Insert Diagnosis Code]
- **Estimated Date of Service:** [Insert Date]

Enclosed are relevant documents including:

- Patient's dental records
- X-rays or imaging reports
- Letter from the referring dentist

We appreciate your prompt attention to this matter and look forward to your approval.

Sincerely,

[Your Name]

[Your Title]

[Dental Practice Name]

[Dental Practice Address]

[Phone Number]

[Email Address]