

Confirmation of Pre-Authorization

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Dear [Insurance Representative's Name],

We are writing to confirm the pre-authorization for the surgical procedure scheduled for [Patient's Name] on [Date of Procedure]. This letter serves to acknowledge that the necessary approvals for the following surgical expenses have been granted:

- Procedure: [Type of Surgery]
- Provider: [Surgeon's Name/Facility Name]
- Estimated Cost: [Cost Amount]
- Authorization Number: [Authorization Number]

Please ensure that all related expenses are processed according to the pre-authorized agreement. If you require any additional information or documentation, feel free to contact me at [Your Phone Number] or via email at [Your Email Address].

Thank you for your assistance in this matter.

Sincerely,

[Your Name]

[Your Job Title]

[Your Organization] (if applicable)