Pre-Authorization Notification

Date: [Insert Date]

Recipient Name: [Insert Recipient Name]

Recipient Address: [Insert Recipient Address]

City, State, Zip: [Insert City, State, Zip]

Dear [Recipient Name],

We are writing to inform you that your request for pre-authorization for prescription coverage for [Insert Medication Name] has been received.

Your healthcare provider has submitted the necessary documentation, and we are currently reviewing the information to determine eligibility for coverage under your plan.

Important Details:

- **Medication Name:** [Insert Medication Name]
- **Prescribing Physician:** [Insert Physician Name]
- **Review Status:** [In Progress/Approved/Denied]
- **Expected Completion Date:** [Insert Date]

If you have any questions or need additional information, please do not hesitate to contact our customer service team at [Insert Phone Number] or [Insert Email Address].

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Title]

[Your Organization]

[Your Contact Information]