Request for Pre-Authorization of Medical Coverage Benefits

[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]

[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]

Dear [Insurance Company Representative's Name],

I am writing to formally request pre-authorization for medical coverage benefits for [specific treatment or procedure] that has been recommended by my physician, Dr. [Physician's Name]. The details of the treatment are as follows:

- **Patient Name:** [Your Name]
- **Policy Number:** [Your Policy Number]
- **Diagnosis:** [Diagnosis, if applicable]
- **Proposed Treatment/Procedure:** [Detailed description of the treatment/procedure]
- **Scheduled Date:** [Date of the scheduled treatment]

The rationale for this request is based on [a brief explanation of the medical necessity, including any relevant medical history or documented evidence].

I kindly ask that you process this request at your earliest convenience, as the treatment is time-sensitive. Please feel free to contact me or Dr. [Physician's Name] at [Physician's Phone Number] if you require any additional information or documentation.

Thank you for your prompt attention to this matter. I look forward to your positive response.

Sincerely,

[Your Signature (if sending a hard copy)]
[Your Printed Name]