Pre-Authorization Request for Therapy Benefits

Date: [Insert Date]

Recipient Name: [Insert Recipient Name]

Insurance Company: [Insert Insurance Company Name]

Address: [Insert Insurance Company Address]

Policy Number: [Insert Policy Number]

Member ID: [Insert Member ID]

Dear [Recipient Name],

I am writing to formally request pre-authorization for therapy benefits for my patient, [Patient's Full Name], who has been diagnosed with [Diagnosis]. Given the circumstances surrounding their condition, I believe that [specific therapy treatment] is medically necessary.

Details of therapy treatment are as follows:

- **Type of Therapy:** [Type of Therapy]
- **Frequency:** [Frequency of Treatment]
- **Duration:** [Expected Duration]

Attached, you will find the requested documentation supporting this pre-authorization request, including the patient's medical records and a treatment plan outlining the necessity of the proposed therapy.

Thank you for your prompt attention to this matter. If you require any further information or documentation, please do not hesitate to contact me at [Your Phone Number] or [Your Email Address].

Sincerely,

[Your Name]

[Your Title]

[Your Practice/Organization Name]

[Your Address]

[Your Phone Number]

[Your Email Address]