

Oncology Treatment Insurance Authorization

Date: [Insert Date]

Patient Name: [Patient's Full Name]

Patient ID: [Patient ID/Reference Number]

Insurance Provider: [Insurance Company Name]

Insurance Policy Number: [Policy Number]

Provider Name: [Oncologist's Name]

Provider Address: [Provider's Address]

Subject: Request for Authorization for Oncology Treatment

Dear [Insurance Company Representative's Name],

I am writing to request authorization for [specific oncology treatment], as recommended for my patient, [Patient's Full Name], who has been diagnosed with [Cancer Diagnosis] on [Date of Diagnosis].

The requested treatment is medically necessary and is supported by the following clinical rationale:

- [Reason 1]
- [Reason 2]
- [Reason 3]

Enclosed are the necessary documents, including treatment plans, medical history, and any relevant test results.

We appreciate your prompt attention to this matter and look forward to your approval. Please feel free to contact me at [Provider's Phone Number] or [Provider's Email] should you require any further information.

Thank you for your cooperation.

Sincerely,

[Oncologist's Name]

[Oncologist's Title]

[Oncologist's Practice Name]

[Practice Contact Information]