Insurance Pre-Authorization Reconsideration Request

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Subject: Reconsideration Request for Pre-Authorization Denial

Dear [Insurance Company Representative's Name],

I am writing to formally request a reconsideration of the pre-authorization denial for [specific treatment or procedure] for my [relationship to patient, e.g., my son, my daughter, etc.], [Patient's Name], following the reference number [Authorization Denial Reference Number].

The denial letter dated [Date of Denial Letter] stated that the request was denied due to [briefly state the reason given for the denial]. I believe this decision should be reconsidered based on the following information:

- [Detail 1 - explanation or additional documentation supporting the request]
- [Detail 2 - additional relevant medical facts or treatment history]
- [Detail 3 - any other supporting evidence]

Your prompt attention to this matter would be greatly appreciated, as [Patient's Name] requires timely access to [treatment/procedure]. I have enclosed [list any documents enclosed] for your review.

Please feel free to contact me at [Your Phone Number] or [Your Email Address] should you need any further information.

Thank you for your consideration.

Sincerely,

[Your Name]