Durable Medical Equipment Insurance Authorization Request

Date: [Insert Date]

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

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

Dear [Insurance Company Representative's Name],

I am writing to request authorization for the durable medical equipment necessary to treat my medical condition. The details of the equipment are as follows:

Patient Name: [Patient's Name]
Date of Birth: [Patient's DOB]
Medical Diagnosis: [Diagnosis]
Requested Equipment: [Description of Equipment]

This equipment is essential for [explain the medical necessity and how it will benefit the patient].

Please find attached the supporting documentation, including the physician's order, medical records, and any other relevant information.

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

Sincerely,

[Your Name]
[Your Title, if applicable]