Durable Medical Equipment Prior Authorization Request

To: [Insurance Company Name]

From: [Your Name]
[Your Title]
[Your Organization]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

Date: [Date]

Patient Information:

Name: [Patient Name]
Date of Birth: [Patient DOB]
Insurance ID: [Insurance ID Number]
Policy Number: [Policy Number]

Requesting Equipment:

[Specify the Durable Medical Equipment (DME) requested]

Medical Necessity:

[Provide a brief explanation of the medical necessity for the requested DME, including relevant diagnoses and treatment plans.]

Supporting Documentation:

[List any attached documents such as medical records, prescriptions, or provider notes that support the request.]

Requested Action:

Please provide prior authorization for the above stated durable medical equipment.

Signature:
[Your Name]
[Your Title]

[Your Organization]
[Your Contact Information]