Insurance Pre-Authorization Request

Date: [Insert Date]

Patient Information:
Name: [Patient Name]
Date of Birth: [Patient DOB]
Insurance Provider: [Insurance Company Name]
Policy Number: [Policy Number]

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

Subject: Pre-Authorization Request for Diagnostic Imaging

Dear [Insurance Company Representative's Name],

I am writing to request pre-authorization for diagnostic imaging services for my patient, [Patient Name]. The requested imaging procedure is as follows:

- Procedure: [Type of Imaging, e.g., MRI, CT Scan]
- Scheduled Date: [Proposed Date]
- Referring Physician: [Physician's Name]

This imaging is medically necessary for the evaluation of [Brief Explanation of Medical Condition]. The results will assist in determining an appropriate treatment plan.

Please find attached the relevant medical records and supporting documentation pertaining to this request.

Should you require any further information, please do not hesitate to contact me at [Your Contact Information]. I appreciate your prompt attention to this matter.

Sincerely,

[Your Name]
[Your Title/Position]
[Your Institution/Practice Name]
[Contact Information]