# Pre-Authorization Request for Durable Medical Equipment

**Date:** [Insert Date]

**To:** [Insurance Company Name]

**Address:** [Insurance Company Address]

**Policyholder:** [Patient Name]

**Policy Number:** [Policy Number]

**Group Number:** [Group Number]

**Physician Name:** [Referring Physician Name]

**Physician Contact:** [Referring Physician Phone Number]

## Request Details

We are writing to request pre-authorization for the following durable medical equipment:

- **Equipment Name:** [Specify Equipment]
- **Quantity:** [Specify Quantity]
- **Diagnosis:** [Specify Diagnosis]
- **Medical Necessity:** [Brief explanation of medical necessity]

## Supporting Documentation

Attached are the following documents to support this request:

- Detailed prescription from the physician
- Medical records supporting the need for the equipment
- Any additional clinical notes or documentation

## Conclusion

We appreciate your prompt attention to this matter, as it is vital for the patient's health and recovery. Please do not hesitate to contact us if you require any further information.

Thank you for your assistance.

Sincerely,

[Your Name]
[Your Title]
[Your Organization]
[Your Contact Information]