Insurance Pre-Authorization Request for Medication

Date: [Insert Date]

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

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

Dear [Insurance Company Representative's Name],

I am writing to formally request pre-authorization for the following medication:

Medication Name: [Insert Medication Name]
Dosage: [Insert Dosage]
Quantity: [Insert Quantity]
Prescribing Physician: [Insert Doctor's Name]
Physician's Contact Information: [Insert Phone Number and Email]

This medication is essential for the treatment of [Insert Condition] and I believe it is medically necessary for my health. Attached are the relevant medical records and documentation from my healthcare provider justifying this request.

I appreciate your prompt attention to this matter and look forward to your timely response. Should you need additional information, please don't hesitate to contact me.

Thank you for your assistance.

Sincerely,
[Your Name]