Pre-Authorization Request for Outpatient Services

Date: _____

To: [Insurance Company Name]

Address: [Insurance Company Address]

Phone: [Insurance Company Phone Number]

Policyholder: [Patient's Name]

Policy Number: [Patient's Policy Number]

Date of Birth: [Patient's Date of Birth]

Claim Number (if applicable): [Claim Number]

Request Details

Dear [Insurance Representative's Name],

I am writing to request pre-authorization for outpatient services for my patient, [Patient's Name]. The requested services are as follows:

- Service Type: [Specify the type of outpatient service]
- Date of Service: [Proposed date]
- Provider: [Healthcare Provider's Name & Contact Information]

Clinical Information

Diagnosis: [Specify diagnosis]

Reason for Service: [Explain the medical necessity for the service]

Attached Documentation

Please find attached the following documents to support this request:

- Clinical notes
- Previous treatment records
- Any relevant test results

Thank you for your prompt attention to this matter. Please feel free to contact me at [Your Phone Number] or [Your Email] should you require any further information.

Sincerely,

[Your Name]
[Your Title]
[Your Institution/Practice Name]
[Your Address]
[Your Phone Number]
[Your Email]