

[Your Name]

[Your Address]

[City, State, Zip Code]

[Email Address]

[Phone Number]

[Date]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Subject: Pre-Authorization Request for Surgery

Dear [Insurance Company Representative's Name],

I am writing to request pre-authorization for a surgical procedure that has been recommended by my physician, Dr. [Doctor's Name], who can be reached at [Doctor's Phone Number]. The procedure is scheduled for [Date of Surgery] at [Facility Name].

Procedure Details:

- Procedure Name: [Name of Procedure]
- Diagnosis: [Diagnosis Code and Description]
- Estimated Cost: [Estimated Cost]

This procedure is necessary to address [Brief Description of Medical Condition] and will significantly improve my quality of life.

Attached are the relevant medical records and documentation from Dr. [Doctor's Name] that support this request.

Please process this pre-authorization request at your earliest convenience. Should you require any additional information, do not hesitate to contact me at [Your Phone Number] or [Your Email Address].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name]