Specialist Referral Authorization Request

Date: [Insert Date]

To: [Insurance Company Name]

Address: [Insurance Company Address]

Patient Name: [Patient Full Name]

Patient ID: [Patient Identification Number]

Referring Physician: [Referring Physician's Name]

Referring Physician's Contact Information: [Phone Number, Email]

Reason for Referral

[Detailed explanation of the patient's condition and the necessity for specialist consultation. Include relevant medical history and prior treatments.]

Requested Specialist

Specialist Name: [Specialist Full Name]

Specialty: [Specialist's Field of Medicine]

Office Address: [Specialist's Office Address]

Authorization Request

We kindly request authorization for this specialist referral to ensure prompt evaluation and management of the patient's condition. Attached are relevant medical records and documents to support this request.

Signature:

[Referring Physician's Signature]

[Referring Physician's Printed Name]

[Referring Physician's License Number]