Prior Authorization Request

Date: [Insert Date]

To: [Insurance Company Name]

Address: [Insurance Company Address]

Patient Name: [Patient's Full Name]

Patient ID: [Patient ID or Policy Number]

Provider Name: [Your Name or Practice Name]

Provider NPI: [Your NPI Number]

Contact Information: [Your Phone Number] | [Your Email Address]

Request for Prior Authorization

Dear [Insurance Company Representative's Name],

I am writing to request prior authorization for the following durable medical equipment (DME) for my patient, [Patient's Full Name], who has a medical need as outlined below:

Device Details

Device Name: [Insert DME Name]

HCPCS Code: [Insert HCPCS Code]

Quantity: [Insert Quantity]

Medical Necessity

[Provide a brief explanation of the patient's medical condition and why the requested DME is necessary for their treatment.]

Attached Documentation

Enclosed with this letter are the following documents to support this request:

- Medical Records
- Prescription from Attending Physician

- Any Additional Relevant Documents

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

Sincerely,

[Your Full Name]

[Your Title]

[Your Practice Name]

[Your Practice Address]