Prior Authorization Request

Date: [Insert Date]

To: [Insurance Company Name]

Address: [Insurance Company Address]

Patient Name: [Patient's Full Name]

Patient ID: [Patient's Insurance ID]

Provider Name: [Provider's Full Name]

Provider NPI Number: [Provider's NPI Number]

Procedure Requested: [Description of the Medical Procedure]

ICD-10 Code: [Relevant Diagnosis Code]

Current Medical Condition:

[Brief description of patient's current medical condition]

Justification for Procedure:

[Detailed explanation of why the procedure is necessary]

Supporting Documents:

- [List of attached documents such as lab reports, previous treatment records, etc.]

Please review this request for prior authorization and contact me at [Provider's Phone Number] or [Provider's Email Address] if you have any questions or require further information.

Thank you for your attention to this matter.

Sincerely,

[Provider's Full Name]
[Provider's Title]
[Provider's Practice Name]
[Practice Address]
[Practice Phone Number]