Prior Authorization Request for Outpatient Therapy

Date: [Insert Date]

Patient Name: [Patient's Full Name]

Patient ID: [Patient ID Number]

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

Provider Name: [Your Name]

Provider NPI: [Your NPI Number]

Practice Name: [Your Practice Name]

Practice Address: [Your Practice Address]

Contact Number: [Your Contact Number]

To Whom It May Concern:

I am writing to request prior authorization for outpatient therapy services for my patient, [Patient's Full Name], who has been diagnosed with [Diagnosis/Condition]. The following details outline the request:

Requested Services:

- Type of Therapy: [e.g., Physical Therapy, Occupational Therapy, Speech Therapy]
- Frequency: [e.g., 2 times per week]
- Duration: [e.g., 8 weeks]

Clinical Justification:

[Provide a brief explanation of the patient's condition and the necessity for outpatient therapy, including any relevant clinical information or previous treatments undertaken.]

Enclosures:

- Patient's Medical Records
- Referral Letter
- Any Additional Supporting Documents

Thank you for your attention to this request. Please feel free to contact me at [Your Contact Number] if you need any further information.

Sincerely,

[Your Name]
[Your Title]