Prior Authorization Request

Date: [Insert Date]

Recipient Name: [Insert Recipient Name]

Recipient Address: [Insert Recipient Address]

Insurance Provider: [Insert Insurance Company Name]

Policy Number: [Insert Policy Number]

Patient Information

Patient Name: [Insert Patient Name]

Date of Birth: [Insert Patient Date of Birth]

Patient ID: [Insert Patient ID]

Request Details

We are requesting prior authorization for the following preventive service:

- **Type of Service:** [Insert Type of Preventive Service]
- **Date of Service:** [Insert Expected Date of Service]
- **Provider Name:** [Insert Provider Name]
- **Provider NPI:** [Insert Provider NPI]

Reason for Request

[Insert detailed explanation of why the preventive service is necessary and any relevant clinical information.]

Attachments

Enclosed are relevant documents including:

- [Insert Document 1]
- [Insert Document 2]
- [Insert Document 3]

Contact Information

If you require further information, please do not hesitate to contact me at:

Phone: [Insert Phone Number]

Email: [Insert Email Address]

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Title]

[Your Organization]