Prior Authorization Request for Surgical Procedure

Date: [Insert Date]

To: [Insurance Company Name]

Attn: Prior Authorization Department

Provider Name: [Insert Provider Name]

Provider Address: [Insert Provider Address]

Provider Phone Number: [Insert Phone Number]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

Insurance ID Number: [Insert Insurance ID]

Subject: Prior Authorization Request for [Insert Surgical Procedure]

Dear [Insurance Company Name] Prior Authorization Team,

I am writing to request prior authorization for the surgical procedure [Insert Surgical Procedure] for my patient, [Insert Patient Name]. This procedure is medically necessary due to [Insert Reason for Surgery].

Details of the Procedure:

- **Procedure Code:** [Insert Procedure Code]
- **Date of Procedure:** [Insert Expected Date]
- **Facility:** [Insert Facility Name]

Attached are the relevant clinical notes and any supporting documentation that outlines the medical necessity of this procedure.

Please feel free to contact me at [Insert Phone Number] or [Insert Email Address] should you require any further information.

Thank you for your attention to this matter.

Sincerely,

[Your Name]
[Your Title]
[Your Practice Name]