

[Your Name]  
[Your Address]  
[City, State, Zip Code]  
[Email Address]  
[Phone Number]  
[Date]

[Insurance Company Name]  
[Claims Department Address]  
[City, State, Zip Code]

Re: Prescription Authorization Request for [Patient's Name]

Policy Number: [Policy Number]

Claim Number: [Claim Number]

Dear [Insurance Company/Representative's Name],

I am writing to request prior authorization for the prescription of [Medication Name] for my patient, [Patient's Name], who has been diagnosed with [Condition or Diagnosis].

The prescribed medication is essential for managing the patient's symptoms and improving their quality of life. According to my records, [Patient's Name] has tried and failed on [List any alternative medications or treatments, if applicable], which necessitates the use of [Medication Name].

Enclosed, you will find the following documents supporting this request:

1. Prescription from [Doctor's Name, MD]
2. Detailed medical records
3. A summary of treatment history
4. Any additional relevant documentation

Please feel free to contact me at [Your Phone Number] or [Your Email Address] if you require further information or clarification regarding this request.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name]  
[Your Title/Position]  
[Your Medical Practice or Institution Name]  
[Your NPI Number, if applicable]  
[Enclosures: List of enclosed documents]