[Your Name]
[Your Title/Position]
[Your Clinic/Practice Name]
[Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Prior Authorization Department]
[Insurance Company's Address]
[City, State, Zip Code]
Subject: Request for Prescription Prior Authorization
Dear [Insurance Company Contact/Department],
I am writing to request prior authorization for the medication [Medication Name] for my patient, [Patient's Full Name], [Patient's Date of Birth], [Patient's Insurance ID Number].
Patient Details:
- Name: [Patient's Full Name]
- Date of Birth: [Patient's Date of Birth]
- Insurance ID: [Patient's Insurance ID Number]
- Diagnosis: [Patient's Diagnosis]
- Prescribing Doctor: [Your Full Name]
- NPI Number: [Your NPI Number]
Medication Details:
- Medication Name: [Medication Name]
- Dosage: [Dosage]
- Quantity: [Quantity prescribed]
- Frequency: [Frequency of administration]
Clinical Need:
[Briefly describe the medical necessity for the prescribed medication and any relevant treatment history or previous medications tried and failed.]
Enclosed you will find:
1. The prescription for [Medication Name].
2. Clinical notes supporting the need for this medication.
3. Any other relevant documentation.
Please let me know if you require any further information to process this request. I appreciate your prompt attention to this matter and look forward to your response.
Sincerely,
[Your Signature (if sending a hard copy)]
[Your Printed Name]
[Your Title/Position]
[Your Clinic/Practice Name]