[Your Name]
[Your Title]
[Your Organization/Practice Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Claims Department/Specific Department]
[Insurance Company Address]
[City, State, Zip Code]
Re: Request for Clinical Authorization for [Patient's Name]
Policy Number: [Patient's Policy Number]
Date of Birth: [Patient's Date of Birth]
Diagnosis: [Diagnosis/ICD Code]
Dear [Insurance Company Representative's Name],
I am writing to request prior authorization for [specific medication/procedure] for my patient, [Patient's Name], who has been under my care since [date]. This request is based on [brief explanation of the patient's condition and the necessity of the requested treatment].
The details of the request are as follows:
- **Medications/Procedure Requested:** [Name of medication/procedure]
- **Dosage/Duration:** [Dosage and duration, if applicable]
- **Medical Necessity:** [Concise justification for the treatment, including any previous treatments tried and their outcomes.]
Attached are the patient's medical records, relevant test results, and any other documentation supporting this request for your review.
We believe that this treatment is essential for [Patient's Name] to manage their condition effectively and improve their quality of life.
Please do not hesitate to contact me if further information is required.
Thank you for your prompt attention to this matter.
Sincerely,
[Your Signature (if sending a hard copy)]
[Your Printed Name]
[Your Medical License Number]