[Your Name]
[Your Title/Position]
[Your Organization]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Claims Department]
[Insurance Company's Address]
[City, State, Zip Code]
Re: Medical Prescription Authorization Request
Patient: [Patient's Name]
Date of Birth: [Patient's DOB]
Policy Number: [Patient's Policy Number]
Rx Number: [Prescription Number]
Dear [Insurance Representative's Name or "Claims Department"],
I am writing to request prior authorization for the medication prescribed to my patient, [Patient's Name]. After thorough evaluation and consideration of the patient's health condition, I have determined that [Medication Name] is medically necessary for the treatment of [Condition/Diagnosis].
Details of the prescription are as follows:
- Medication: [Medication Name]
- Dosage: [Dosage Information]
- Quantity: [Quantity prescribed]
- Duration: [Duration of treatment]
This medication is [Brief explanation of why this medication is necessary, including any previous treatments or medications tried and their outcomes].
Please find attached the supporting documentation, including:
- Patient's medical history
- Documentation of previous treatments
- Any relevant lab results or imaging studies
I appreciate your prompt attention to this matter. Please do not hesitate to contact me at [Your Phone Number] or [Your Email Address] should you require any further information or clarification.
Thank you for your consideration.
Sincerely,
[Your Name]
[Your Title/Position]
[Your Organization]