[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Recipient Name]
[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]
Re: Authorization Request for [Patient's Name]
Member ID: [Patient's Member ID]
Date of Birth: [Patient's Date of Birth]
Dear [Recipient Name / Health Care Provider / UHC Customer Service],
I am writing to request authorization for [specific treatment, procedure, medication, etc.] for my patient, [Patient's Name]. This request is prompted by [briefly explain the medical necessity or reason for the treatment].
Details of Request:
- Procedure/Treatment: [Name of procedure/treatment]
- CPT Code: [CPT Code, if applicable]
- Diagnosis Code: [ICD-10 Code, if applicable]
- Provider: [Name of the referring provider]
- Provider NPI: [Provider's NPI Number]
- Date of Service: [Requested date of service, if applicable]
Clinical History:
[Provide a brief overview of the patient's medical history and any relevant details that support the request.]
I have attached the necessary documentation, including [list any supporting documents, such as clinical notes, lab results, etc.].
Thank you for your prompt attention to this matter. Please feel free to contact me at [your phone number] or [your email address] if you require any additional information.
Sincerely,
[Your Name]
[Your Title/Position]
[Your Practice/Hospital Name]
[Your NPI Number] (if applicable)