

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

[Date]

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

RE: Request for Authorization for Developmental Testing

Patient Name: [Patient Full Name]
Policyholder Name: [Policyholder Name]
Policy Number: [Policy ID Number]
Group Number: [Group Number]
Patient Date of Birth: [MM/DD/YYYY]

To Whom It May Concern,

I am writing to formally request prior authorization for comprehensive developmental and diagnostic testing for [Patient Name]. This testing has been recommended by [Referring Physician's Name] due to observed delays in [mention specific areas, e.g., speech, motor skills, social interaction].

The requested evaluations include:

- [CPT Code]: [Description of Test/Evaluation]
- [CPT Code]: [Description of Test/Evaluation]

Testing is scheduled to be performed by [Provider/Clinic Name] on [Date, if applicable].

Medical necessity is based on the following symptoms and observations: [Briefly list symptoms or attach a letter of medical necessity from the doctor]. Early intervention and accurate diagnosis are critical for determining the appropriate therapeutic path and improving long-term outcomes for the patient.

Please find the attached supporting documentation, including the physician's referral and relevant clinical notes. I look forward to a timely response regarding this authorization. If you require further information, please contact me at [Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures: [Physician Referral, Medical Records, Supporting Documents]