

Date: [Date]

To: [Insurance Company Name]

Attn: Prior Authorization Department

Fax/Address: [Fax Number or Mailing Address]

RE: Request for Prior Authorization for Oncology Second Opinion

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Member ID: [Insurance ID Number]

Group Number: [Group Number]

Dear Medical Review Officer,

I am writing to formally request authorization for a second opinion oncology consultation for the above-referenced patient. [Patient Name] has been diagnosed with [Specific Diagnosis/Type of Cancer, e.g., Stage III Invasive Ductal Carcinoma].

Provider Information:

Requesting Physician: [Name of Current Oncologist]

Consulting Physician/Facility: [Name of Second Opinion Specialist and Institution]

Reason for Request:

A second opinion is medically necessary to:

- Confirm the initial diagnosis and pathology results.
- Evaluate the proposed treatment plan (e.g., chemotherapy, radiation, surgery).
- Explore clinical trial eligibility or alternative therapeutic options.
- Ensure the most effective and cost-efficient course of care for this complex diagnosis.

The requested consultation is scheduled for [Date, if applicable] under CPT Code: [e.g., 99205 - Office/Outpatient Consultation].

Attached please find the patient's initial pathology reports, diagnostic imaging results, and the current treatment summary for your review.

Thank you for your prompt attention to this matter. Please notify my office of your decision by [Phone Number] or [Fax Number].

Sincerely,

[Your Name/Signature]

[Title/Office Name]

[Phone Number]