

[Date]

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

RE: Prior Authorization Request for Allergy and Immunology Consultation

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

To Whom It May Concern,

I am writing to request prior authorization for a specialized Allergy and Immunology consultation and diagnostic testing for the above-referenced patient. This referral is medically necessary to evaluate, diagnose, and manage the patient's clinical symptoms.

Clinical Documentation:

- **Primary Diagnosis/Symptoms:** [e.g., Chronic Urticaria, Recurrent Sinusitis, Suspected Food Allergy]
- **ICD-10 Code(s):** [Insert Code, e.g., L50.0, J32.9]
- **Medical Necessity:** [Briefly describe failed previous treatments or severity of symptoms]

Requested Services:

- New Patient Consultation (CPT 99203-99205)
- Allergy Skin Testing (CPT 95004, 95024)
- In-Vitro Specific IgE Testing (CPT 86003)
- [List any other specific tests required]

Provider Information:

Referring Provider: [Name, NPI, and Phone]
Specialist Provider: [Name of Allergy/Immunology Clinic, NPI]

Please review this request and provide a determination via fax to [Fax Number] or by mail. If further clinical documentation is required, please contact my office at [Phone Number].

Sincerely,

[Provider Signature]

[Provider Printed Name]

[Practice Name]