Date: [Date]

TO: [Insurance Company Name]
ATTN: Prior Authorization Department
FAX/ADDRESS: [Fax Number or Address]

RE: Initial Prior Authorization Request for Home Oxygen Therapy

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Policy/Group Number: [Group Number]

Dear Prior Authorization Department,

I am writing to request prior authorization for home oxygen therapy equipment for the above-mentioned patient. This equipment is medically necessary to treat [Primary Diagnosis/ICD-10 Code].

Clinical Documentation:

- **Qualifying Lab Test:** [Arterial Blood Gas (ABG) or Pulse Oximetry]
- **Test Date:** [Date of Test]
- **Result:** [PO2 value or Oxygen Saturation %]
- **Condition during test:** [At rest / During exercise / During sleep]

Prescribed Equipment and Orders:

- **Equipment Requested:** [e.g., Oxygen Concentrator, Portable Tanks, or Stationary Liquid System]
- **Flow Rate:** [e.g., 2 Liters Per Minute]
- **Frequency:** [e.g., Continuous, Nocturnal only, or PRN]
- **Estimated Duration:** [e.g., Lifetime or 12 months]

The patient has been evaluated for alternative treatments, and it has been determined that supplemental oxygen is required to maintain adequate blood oxygen levels and prevent further medical complications. Attached you will find the formal prescription and relevant clinical notes.

Please contact my office at [Phone Number] if you require additional information to process this request.

Sincerely,

[Physician Name, MD/DO]
[NPI Number]

[Facility Name]
[Phone Number]