[Sender Name]
[Sender Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

RE: Reference to Original Prior Authorization

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Original Authorization Number: [Original PA Number]
Original Approval Dates: [Start Date] to [End Date]

To Whom It May Concern,

This letter is to formally reference the previously approved prior authorization (Number: [Original PA Number]) regarding [Service/Medication Name].

We are submitting this correspondence to request a [Extension/Modification/Renewal] of the existing authorization. The original clinical documentation remains valid, and the patient continues to require this treatment for the management of [Diagnosis/ICD-10 Code].

[Insert brief reason for referencing original PA, e.g., "The treatment schedule has shifted," or "A follow-up procedure is required under the same clinical umbrella"].

Please link this request to the original authorization file to ensure continuity of care and expedited processing. If further documentation is required, please contact my office at [Phone Number].

Sincerely,

[Provider Name/Signature]
[NPI Number]
[Facility Name]