

[Your Name]
[Your Address]
[Your Phone Number]
[Your Email]

[Date]

[Recipient Name/Insurance Provider Name]
[Department Name]
[Address]

RE: Request for Additional Therapy Sessions

Patient Name: [Patient Full Name]
Policy/Member ID: [ID Number]
Claim/Case Number: [Case Number, if applicable]

Dear [Contact Person or Department],

I am writing to formally request approval for [Number] additional therapy sessions for [Patient Name]. The current authorized sessions are scheduled to conclude on [Date].

The patient is receiving treatment for [Diagnosis/Reason for Therapy]. While significant progress has been made in [mention specific goal or area of improvement], continued therapeutic intervention is necessary to address [mention remaining symptoms or specific treatment goals].

Clinical justification for this request includes:

- [Briefly describe clinical need]
- [Briefly describe potential risk of regression without continued care]

I have attached a brief clinical summary and treatment plan from the provider, [Provider Name], to support this request. We aim to achieve [Expected Outcome] through these additional sessions.

Please notify me of your decision by [Date]. If you require further documentation or have any questions, please contact me at [Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name]