Subject: URGENT: Prior Authorization Request - [Patient Name] - [Policy Number] - [Procedure/Medication Name]

[Date]

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

RE: Prior Authorization Request for [Patient Name]

Patient Date of Birth: [DOB]

Member ID Number: [ID Number]

Group Number: [Group Number]

Requesting Provider: [Physician Name]

Provider NPI: [NPI Number]

To Whom It May Concern,

I am writing to request a prior authorization for [Patient Name] to receive [Procedure Name / Medication Name / Equipment]. This treatment is medically necessary for the management of [Diagnosis Name], ICD-10 code [Code].

Clinical Justification:

[Briefly describe patient history, failed previous treatments, and why this specific request is required.]

Attached you will find supporting clinical documentation, including office notes and relevant test results. Please process this request as soon as possible to ensure the patient receives timely care.

If you have any questions or require further information, please contact my office at [Phone Number].

Sincerely,

[Provider Signature]
[Provider Printed Name]
[Title/Practice Name]