Subject: PRIOR AUTHORIZATION REQUEST: [Patient Full Name] - [Patient Date of Birth] - [Member ID Number]

[Date]

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

RE: Prior Authorization Request for [Procedure/Medication Name]

Dear Prior Authorization Department,

I am writing to request a prior authorization for [Patient Name] to receive [Name of Treatment/Medication/Procedure]. This request is based on medical necessity for the treatment of [Diagnosis/ICD-10 Code].

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

Clinical Justification:
[Insert brief summary of patient history, failed previous treatments, and why this specific treatment is required.]

Please find the supporting clinical documentation and office notes attached to this request. We look forward to your timely response regarding this authorization.

Sincerely,

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