[Date]

[Insurance Company Name / Military Health System Branch]
[Claims/Authorization Department]
[Address]
[City, State, Zip Code]

RE: Request for Extension of Outpatient Treatment

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member/Service ID: [ID Number]
Current Authorization Number: [Authorization #]

To Whom It May Concern,

This letter is to formally request an extension of outpatient medical treatment for the above-named servicemember, who is currently receiving care at [Clinic Name] for service-connected injuries/conditions.

The patient is currently being treated for [Brief Description of Condition/Diagnosis]. While progress has been documented, continued clinical intervention is medically necessary to achieve maximum medical improvement and support the patient's recovery goals.

Extension Request Details:

- **Requested Start Date:** [Date]
- **Requested End Date:** [Date]
- **Frequency of Treatment:** [e.g., 2 sessions per week]
- **Type of Service:** [e.g., Physical Therapy, Mental Health Counseling, etc.]

Attached to this request, please find the updated treatment plan and clinical progress notes supporting the necessity of this extension.

If you require further clinical documentation or have questions regarding this request, please contact our office at [Phone Number].

Sincerely,

[Physician/Provider Signature]
[Physician/Provider Name and Credentials]
[Clinic/Facility Name]
[NPI Number]