**Date:** [Insert Date]

**To:** [Insert Pharmacy Name / Program Name]
**Address:** [Insert Pharmacy Address]
**Fax/Phone:** [Insert Contact Information]

**RE: Prescription Authorization for Uninsured Patient Assistance**

**Patient Name:** [Insert Patient Full Name]
**Date of Birth:** [Insert Date of Birth]
**Patient ID/Account Number:** [Insert Number if applicable]

To Whom It May Concern,

This letter serves as formal authorization for the aforementioned patient to receive medications under the **[Insert Name of Assistance Program]**. The patient has been evaluated and meets the financial eligibility criteria as an uninsured individual requiring medical assistance.

**Authorized Prescription(s):**

- **Medication Name:** [Insert Drug Name]
- **Dosage/Strength:** [Insert Dosage]
- **Quantity/Refills:** [Insert Quantity]

**Provider Information:**

**Prescribing Physician:** [Insert Doctor Name]
**NPI Number:** [Insert NPI Number]
**Clinic/Facility Name:** [Insert Facility Name]
**Phone Number:** [Insert Phone Number]

Please process the prescription(s) according to the guidelines of the assistance program. If further documentation or verification is required, please contact our office directly.

Sincerely,

[Signature]
[Print Name and Title]
[Date]