Date: [Insert Date]

To: [Infusion Clinic Name/Admissions Department]
Address: [Clinic Address]
Fax/Phone: [Clinic Contact Information]

RE: Authorization for Outpatient Intravenous Therapy

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Insurance ID: [Policy Number]

To Whom It May Concern,

I am writing to formally authorize and refer the above-named patient for outpatient intravenous (IV) therapy at your facility. Based on my clinical assessment, this treatment is medically necessary for the management of the patient's condition.

Clinical Information:

- **Diagnosis:** [Diagnosis Name and ICD-10 Code]
- **Medication/Treatment:** [Name of Medication or Fluid]
- **Dosage:** [e.g., 500mg or 1 Liter]
- **Frequency:** [e.g., Once daily, Weekly, or Single dose]
- **Duration:** [e.g., 5 days or 6 months]
- **Access Requirement:** [e.g., Peripheral IV, PICC line, or Port-a-Cath]

The patient has been evaluated for contraindications and is cleared to receive this therapy in an outpatient setting. Please provide my office with a treatment summary and any relevant lab results following the completion of the sessions.

If you require further clinical documentation or have questions regarding these orders, please contact my office at [Provider Phone Number].

Sincerely,

[Provider Signature]
Provider Name: [Print Name]
NPI Number: [NPI Number]
Practice Name: [Clinic/Hospital Name]