[Date]

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

RE: Request for Outpatient Intravenous (IV) Therapy Authorization

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

To Whom It May Concern,

This letter is to request formal authorization for outpatient Intravenous (IV) Therapy for the above-named patient. This treatment is medically necessary as prescribed by [Doctor's Name].

Clinical Details:

- **Diagnosis:** [Diagnosis Name]
- **ICD-10 Code:** [Code Number]
- **Requested Medication/Fluid:** [Name of IV Medication]
- **HCPCS Code:** [Code, e.g., J-Code]
- **Frequency/Duration:** [e.g., Once weekly for 8 weeks]
- **Facility Name:** [Outpatient Clinic Name]
- **Facility Tax ID/NPI:** [Provider Identification Numbers]

Medical Necessity:
[Briefly describe why the patient needs this IV treatment and why oral alternatives are not sufficient or have failed].

Attached you will find supporting clinical documentation, including recent lab results and progress notes. Please process this request as soon as possible to ensure the patient's treatment plan is not interrupted.

If you require additional information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Practice Name]