Date: [Date]

To: [Insurance Carrier Name]
Claims Examiner: [Adjuster Name]
Address: [Insurance Company Address]
Fax/Email: [Fax Number or Email Address]

RE: Workers' Compensation Authorization Request
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Claim Number: [Claim Number]
Date of Injury: [Date of Injury]

To Whom It May Concern,

This letter serves as a formal request for authorization of outpatient intravenous (IV) therapy for the above-referenced claimant. Based on the clinical evaluation and the nature of the work-related injury, this treatment is medically necessary.

Requested Services:

- **Facility:** [Clinic/Facility Name]
- **Procedure:** [Specific IV Therapy/Medication Name]
- **CPT Codes:** [Insert CPT Codes, e.g., 96365, 96366]
- **Frequency/Duration:** [e.g., Twice weekly for 4 weeks]
- **Diagnosis Code:** [ICD-10 Code]

The goals of this therapy include [e.g., pain management, infection control, hydration, or medication administration] to facilitate the patient's recovery and eventual return to work.

Please provide a written authorization or a utilization review decision via fax to [Your Fax Number] within [Number] business days. Supporting medical documentation and the physician's prescription are attached to this request.

Should you require further clinical information, please contact our office at [Your Phone Number].

Sincerely,

[Authorized Signature]
[Printed Name and Title]
[Practice/Clinic Name]