[Date]

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

RE: Authorization Request for Outpatient Intravenous Therapy

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

To Whom It May Concern,

I am writing to formally request authorization for [Patient Name] to receive specialized intravenous (IV) therapy at [Outpatient Clinic Name]. This referral is based on a medical necessity to treat the following diagnosis: [Diagnosis Name and ICD-10 Code].

Clinical Justification:
The patient requires the administration of [Medication Name] via intravenous infusion. This treatment is necessary because [briefly state reason, e.g., failure of oral medications, severity of condition, or specific specialist protocol].

Treatment Plan:

- **Medication:** [Drug Name and Dosage]
- **Frequency:** [e.g., Once weekly / Every 4 weeks]
- **Duration:** [e.g., 6 months / 12 months]
- **Facility:** [Clinic Name, NPI Number, and Address]

Please find the attached clinical notes, relevant lab results, and previous treatment history supporting this request. Should you require further clinical information, please contact my office at [Phone Number].

Thank you for your prompt attention to this authorization request.

Sincerely,

[Referring Physician Signature]
[Physician Name, MD/DO]
[Medical Specialty]
[NPI Number]
[Practice Name]