Date: [Insert Date]

To: [Insurance Company Name / Medical Review Department]
Fax/Address: [Insert Fax Number or Address]
Re: Authorization Request for Outpatient IV Antibiotic Therapy

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

Provider Information:
Ordering Physician: [Physician Name]
NPI Number: [NPI Number]
Clinic Name: [Infusion Clinic Name]
Clinic Tax ID: [Tax ID]

Clinical Justification:
Diagnosis: [Primary Diagnosis and ICD-10 Code]
Requested Medication: [Antibiotic Name, Dosage, and Frequency]
Duration of Treatment: [Number of Days/Weeks]
Reason for IV Route: [e.g., Failed oral therapy, Severity of infection, Bioavailability requirements]

This letter serves as a formal request for authorization of outpatient intravenous antibiotic infusion therapy for the aforementioned patient. This treatment is medically necessary to manage the patient's current infection and to prevent hospital readmission.

Please review this request and provide an authorization number at your earliest convenience. Supporting clinical notes and lab results are attached for your review.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Contact Phone Number]