Date: [Insert Date]

To: [Insurance Company Name / Medical Director]
Address: [Insurance Company Address]
Fax/Phone: [Insert Contact Information]

RE: Authorization Request for Outpatient Intravenous Chemotherapy

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

Dear Authorization Department,

I am writing to request formal authorization for **[Patient Name]** to receive intravenous (IV) chemotherapy and related supportive care treatments at our outpatient clinic.

Clinical Diagnosis: [Insert Diagnosis, e.g., Stage III Breast Cancer]
ICD-10 Code: [Insert Code]
Requested Treatment Protocol: [Insert Regimen Name, e.g., AC-T]
Proposed Start Date: [Insert Date]
Estimated Duration: [Number of Cycles/Months]

The requested treatment plan includes:

- Chemotherapy Infusion: [List Drugs, e.g., Cyclophosphamide, Doxorubicin]
- Pre-medications: [Anti-emetics, Steroids, or Hydration]
- Nursing services and outpatient facility fees
- Laboratory monitoring as required by the protocol

This treatment is medically necessary based on current clinical guidelines and the patient's specific diagnosis. Delays in starting this therapy may negatively impact the patient's prognosis.

Please find the attached clinical notes, pathology reports, and physician orders supporting this request. If you require further documentation, please contact our office at [Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Physician Name]
[NPI Number]
[Facility/Clinic Name]
[Contact Phone Number]