Date: [Insert Date]

To: [Insurance Company Name / Medical Review Board]
Address: [Insurance Company Address]
Phone: [Insurance Company Phone Number]

RE: Authorization Request for Nutritional Hydration Intravenous (IV) Therapy

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

To Whom It May Concern,

I am writing to formally request authorization for **Nutritional Hydration Intravenous (IV) Therapy** for the above-mentioned patient at [Clinic Name], an outpatient facility.

Diagnosis and Clinical Indication:
The patient has been diagnosed with [Diagnosis Name, e.g., Chronic Malabsorption, Severe Dehydration, or Vitamin Deficiency] (ICD-10 Code: [Insert Code]). Due to [Reason, e.g., inability to tolerate oral intake or failure of oral supplementation], this outpatient IV therapy is medically necessary to maintain electrolyte balance and nutritional stability.

Treatment Plan:
The prescribed treatment plan includes [Insert Formula/Ingredients, e.g., Normal Saline with B-Complex and Magnesium]. The frequency of treatment is scheduled for [Number] sessions per [Week/Month] for a duration of [Total Length of Treatment].

Provider Information:
Clinic Name: [Name of Outpatient Clinic]
NPI Number: [Clinic NPI]
Ordering Physician: [Physician Name]
Contact Number: [Clinic Phone Number]

Please review this request for medical necessity. If you require additional clinical documentation or have any questions, please contact our office at [Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]