Date: [Date]

To: [Insurance Company Name]
Attn: Utilization Management / Prior Authorization Department
Fax/Address: [Fax Number or Mailing Address]

RE: Request for Out-of-Network Outpatient IV Therapy Authorization

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID Number: [Member ID]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to request a formal prior authorization for [Patient Name] to receive outpatient intravenous (IV) therapy at [Clinic Name], which is an out-of-network provider.

Clinical Justification:
The patient has been diagnosed with [Diagnosis/ICD-10 Code]. The prescribed treatment plan involves [Name of Medication/Infusion] to be administered [Frequency, e.g., once weekly] for a duration of [Number of Months/Weeks].

Request for Out-of-Network Exception:
We are requesting an exception to use this specific clinic because:
[Insert Reason: e.g., Lack of in-network providers within a 50-mile radius / Continuity of care / Specific medication availability / Special equipment required].

Provider Information:
Clinic Name: [Clinic Name]
NPI Number: [Provider NPI]
Tax ID: [Tax ID]
Address: [Clinic Address]
Phone: [Phone Number]

Requested Codes:
HCPCS Code: [Drug Code, e.g., J-code]
CPT Codes: [Administration Codes, e.g., 96365]

Attached you will find the clinical notes, laboratory results, and the signed physician's order supporting this request. Please process this authorization as [Standard/Urgent].

Thank you for your prompt attention to this matter. If you require additional information, please contact my office at [Your Phone Number].

Sincerely,

[Physician Name]
[Title]
[Practice Name]