

Date: [Date]

To: [Pharmacy Name / Insurance Carrier Name]

Attn: Workers' Compensation Department

Fax/Email: [Fax Number or Email Address]

RE: AUTHORIZATION FOR POST-SURGICAL MEDICATION

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Claim Number: [Claim Number]

Date of Injury: [Date of Injury]

Employer: [Employer Name]

Date of Surgery: [Date of Surgery]

To Whom It May Concern,

This letter serves as formal notification and medical authorization for the medications prescribed to the above-named patient following their surgical procedure on [Date of Surgery].

The surgery performed was: [Name of Surgical Procedure].

The following medications are medically necessary for post-operative recovery, pain management, and the prevention of complications (such as infection or blood clots) related specifically to the work injury:

- [Medication Name, Dosage, and Frequency]
- [Medication Name, Dosage, and Frequency]
- [Medication Name, Dosage, and Frequency]

Please expedite the processing of these prescriptions to ensure there is no delay in the patient's recovery process. If further documentation or a Peer-to-Peer review is required, please contact our office immediately at [Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Medical Practice Name]

[Tax ID/NPI Number]