

**Date:** [Date]

**TO:** [Insurance Carrier Name / Adjuster Name]

**FAX/EMAIL:** [Fax Number or Email Address]

**RE:** Prescription Authorization Request

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Claim Number:** [Claim Number]

**Date of Injury:** [Date of Injury]

To Whom It May Concern,

I am the treating physician for the above-referenced patient regarding their work-related injury. The patient is currently under my care for chronic pain management.

At this time, I am requesting immediate authorization for the following medication(s):

- **Medication Name:** [Name of Drug]
- **Dosage/Frequency:** [e.g., 10mg, twice daily]
- **Quantity:** [e.g., 30-day supply with 2 refills]
- **ICD-10 Code:** [Diagnosis Code]

**Medical Necessity:**

This medication is medically necessary to treat the patient's [Specific Condition/Pain Type] resulting from the industrial injury. This treatment is consistent with [MTUS/ODG] guidelines. Failure to provide this medication may result in an exacerbation of symptoms and a delay in the patient's functional recovery.

Please provide a written authorization or a Utilization Review (UR) decision within the legally required timeframe. If you require further clinical documentation, please contact our office immediately.

Sincerely,

[Physician Signature]

**Provider Name:** [Physician Name]

**Practice Name:** [Clinic Name]

**Phone:** [Phone Number]