Date: [Date]

To: [Insurance Carrier/Claims Administrator Name]
Address: [Street Address]
City, State, Zip: [City, State, Zip Code]
Fax/Email: [Fax Number or Email Address]

RE: Request for Prior Authorization of Medication
Claimant Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Date of Injury: [Date of Injury]
Claim Number: [Claim Number]

To Whom It May Concern,

I am writing to formally request prior authorization for the following medication(s) prescribed to the above-named claimant for treatment related to their work-related injury:

- **Medication Name:** [Drug Name and Strength]
- **Dosage/Frequency:** [e.g., 10mg, twice daily]
- **Quantity:** [e.g., 30-day supply with 3 refills]
- **Estimated Duration:** [Estimated length of treatment]

Clinical Justification:
The requested medication is medically necessary to treat [Diagnosis/Symptoms]. This treatment is consistent with the [State Name, if applicable] Workers' Compensation Medical Treatment Guidelines. [Optional: Briefly mention failed previous treatments or why this specific drug is required].

Please provide a written determination regarding this authorization request within [Number] business days to ensure there is no disruption in the patient's care.

If you require additional medical records or have questions, please contact our office at [Phone Number].

Sincerely,

[Physician Signature]
Physician Name: [Printed Name]
NPI Number: [NPI Number]
Practice Name: [Clinic/Hospital Name]
Phone: [Phone Number]