[Your Name]
[Your Address]
[Your Phone Number]
[Your Email Address]

[Date]

[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]

**RE: Request for Prior Authorization for Diagnostic Cardiology Testing**

**Patient Name:** [Patient Full Name]
**Policy Number:** [Insurance Policy Number]
**Group Number:** [Insurance Group Number]
**Date of Birth:** [Patient Date of Birth]

To Whom It May Concern,

I am writing to formally request coverage and prior authorization for the following diagnostic cardiology procedure(s) prescribed by my physician, [Physician Name]:

- [Name of Test, e.g., Echocardiogram, Stress Test, Holter Monitor]
- [CPT Code, if known]

These tests have been ordered to evaluate symptoms of [list symptoms, e.g., chest pain, shortness of breath, palpitations] and to rule out [list potential conditions, e.g., coronary artery disease, arrhythmia]. This diagnostic evaluation is medically necessary to determine an appropriate treatment plan and ensure patient safety.

Attached you will find the physician's referral and relevant medical notes supporting the necessity of these tests.

Please provide a written response regarding the status of this authorization request by [Date]. If you require additional information, please contact my physician's office at [Physician Phone Number] or contact me directly.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]