Date: [Date]

[Referring Provider Name]
[Practice Name]
[Address]
[City, State, Zip Code]

To: [Receiving Provider/Specialist Name]
[Practice Name]
[Address]
[City, State, Zip Code]

RE: Patient Referral

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Medicare ID: [Medicare Number]
Supplement/Medigap Plan: [Plan Name, e.g., Plan G] - [Carrier Name]

Dear Dr. [Receiving Provider Last Name],

I am referring [Patient Name] to your office for evaluation and management of [Reason for Referral/Diagnosis].

The patient is currently covered by Original Medicare (Part A and Part B) and has a Medicare Supplement (Medigap) policy. Since this is a Supplement plan and not a Medicare Advantage plan, prior authorization from an HMO/PPO network is typically not required, provided the service is a Medicare-covered benefit.

Please find the following documents attached for your review:

- Relevant clinical notes and history
- Current medication list
- Recent diagnostic test results
- Copy of Medicare and Supplement insurance cards

Please notify my office of your findings and the recommended treatment plan following the consultation. If you have any questions, please contact us at [Phone Number].

Sincerely,

[Signature]
[Referring Provider Name, Title]
[NPI Number]