Date

Insurer Details
Company Name
Company Address

Patient Details
First and Last Name
Insurance Policy Number
Insurance Group Number
Reference Number (if applicable)

To Whom It May Concern,

I am writing to formally request **[prior authorization/an appeal]** for **[name of treatment, procedure or medication]** on behalf of **[Patient Name]**. This letter outlines **[Patient Name]**'s clinical history, treatment rationale, and expected prognosis.

Patient History and Diagnosis
[Patient Name] has been under my care since **[date]**. They were diagnosed with **[diagnosis name and ICD-10 Code]**, which is a condition characterized by **[briefly describe the severity and symptoms of the patient/disease]**.

Summary of Patient's Medical History and Treatments
Prior to prescribing **[requested treatment]**, the patient has tried and failed the following therapies:

1. **[List each previous treatment by name, then duration, side effects, and reason for failure if applicable]**.

Given the patient's clinical history and diagnosis, **[requested treatment]**is medically appropriate and necessary. **[Explain why this treatment/procedure/diagnostic test is the best, medically appropriate next step, i.e., "This medication is standard of care when a patient presents with…"].**

Clinical Outcome and Prognosis
The goal of this **[treatment/diagnostic/procedure]** is to **[describe the desired outcome, i.e., reduce disease progression, improve function and quality of life, obtain a diagnosis in order to properly treat, etc.].** Without **[requested outcome]**, the patient is at risk of **[describe potential outcomes, decline in health, and or complications without proposed action].**

I have reviewed the relevant medical literature and practice guidelines **[include supporting clinical research/peer reviewed articles (optional but encouraged)]**, which substantiate the need for **[requested treatment/diagnostic/procedure]** for the patient's condition and care.

Thank you for your prompt attention to this request. I believe this **[requested treatment/diagnostic/procedure]** is critical for my patient's health and well-being. Please contact my office at **[phone number]** if you require any additional clinical documentation or information.

Sincerely,

[Physician's Signature]

[Physician's Name, Credentials, NPI Number]