Prior Authorization Medical Request

Subject: Prior Authorization Request for [Treatment/Medication Name]

Dear Medical Review Department,

I am submitting this prior authorization request for [specific treatment/medication/procedure] as prescribed by my treating physician, Dr. [Name], for my diagnosed condition of [medical condition].

My medical history includes [relevant background], and conservative treatments including [list previous treatments] have proven insufficient. My physician has determined that [requested treatment] is the appropriate next step in my care plan based on [clinical reasoning].

Clinical justification for this request includes:

- [Specific medical reason 1]
- [Specific medical reason 2]
- [Urgency factors if applicable]

I understand that prior authorization is required under my current plan, and I am providing all necessary documentation to facilitate a timely review. Please find enclosed my complete medical records, physician's treatment plan, and any additional supporting materials.

Given the nature of my condition, I respectfully request expedited review of this authorization request. Any delay in treatment could result in [potential consequences].

Please contact my physician's office at [phone number] if additional information is required. I look forward to your prompt approval.

Respectfully,

[Your Name]

[Member ID]