# Ask for prior authorization

Your own letter asking the plan to review medical necessity before care starts, and to tell you in writing what it needs.

**Who fills it in:** you, the patient. Your doctor's office usually sends the formal request; this letter goes alongside it, or ahead of it, so the plan hears from you too.

## How to use it

- Type into the boxes in a PDF reader (Adobe Acrobat Reader, Preview on a Mac, your phone's Files app, or your browser), then save or print. Or print it and write in pen.
- Leave blank anything you don't know yet. Cross out or delete anything that doesn't fit your situation, and add what's missing.
- **The letter starts on page 2.** Print only the pages you need.
- More on how prior authorization works: sclerallensguide.com/insurance/prior-authorization/

## Before you send it

- **Read it through and make it yours.** Change anything that isn't right. Plain, accurate and specific is better than formal.
- **Attach the evidence.** Your letter supports your doctor's letter and records; it doesn't replace them.
- **Keep copies and notes.** Keep your originals and send copies. For each phone call, note the date, time, name and title of the person you spoke to, and what was said.

### This isn't legal advice

These letters are general starting points, written for US health plans. Plans, rules and deadlines differ and change. Your denial letter and plan documents set out the process that applies to you. If you need help, your state's Consumer Assistance Program or Department of Insurance may be able to help with an appeal or external review.

**Your name**

**Date**

**Your address, phone and email**

**To: plan name** as on your card

**Department and address** from your denial letter, card or plan website

**Member name**

**Date of birth**

**Member ID**

**Group number** (optional)

## Re: Request for prior authorization (medical necessity review)

To whom it may concern:

I am writing to ask for prior authorization of:

**Prescribed by my eye doctor**

**of (practice)**

**My eye condition**

**Eyes affected** right, left or both

My doctor has recommended scleral contact lenses because:

I have already tried the following, without enough improvement (optional):

This affects my daily life (optional):

☐ My doctor considers my situation urgent. I am asking you to review this as an expedited request.

My doctor's office is sending a letter of medical necessity and my records. Please let me know in writing:

- whether prior authorization is required for this care, and under which benefit
- what documentation you need, and the written criteria you will use
- your decision, with the authorization or reference number, and how long an approval lasts

If you need anything more, please contact me, or contact my eye doctor at the practice named above.

Thank you,

Signature

Your name