**REQUEST FOR PHYSICIAN REFERRAL FOR PRIOR AUTHORIZATION**

#### Patient Name: **{PATIENT\_NAME}**

Date of Birth: **{PATIENT\_DOB}**

Dear Physician,

On behalf of the High Level Hearing Speech & Hearing Center Staff, we would like to extend our sincere thanks for allowing us to perform your patient’s speech and hearing assessments at our Uptown/ Harahan facility. We are delighted to have you look to us as your valuable referral source for speech and hearing services. The purpose of this letter is to obtain a referral/medical clearance as we make an effort to provide our patients with the exemplary treatment. We are requesting the following information in order for the above named patient to receive/ or continue to receive speech or hearing services at our facility:

❑ {SERVICE\_NAME}

Please send the requested information at your earliest convenience to **Attention High Level Speech & Hearing Center** via fax at our billing office at **504-500-5034**. Please feel free to contact our office at **206-866-6974** if you have any questions.

Thank you,



Date: {SIGNATURE\_DATE}