

Date: [Date]

To: [Insurance Company Name]

Attn: Authorization/Utilization Management Department

Fax/Address: [Fax Number or Address]

RE: Request for Prior Authorization

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Member ID: [Member ID Number]

Group Number: [Group Number]

To Whom It May Concern,

I am writing to request prior authorization for a **Pulmonology Consultation and Sleep Study** for the above-mentioned patient.

Requested Services:

- CPT Code: 99204/99205 (New Patient Office Visit)
- CPT Code: 95810/95811 (Polysomnography)
- ICD-10 Code: [Insert Code, e.g., G47.33 for Obstructive Sleep Apnea]

Clinical Justification:

The patient presents with symptoms including [List symptoms: e.g., excessive daytime sleepiness, loud snoring, witnessed gasping/apnea, or morning headaches]. Co-morbidities include [List co-morbidities: e.g., hypertension, BMI over 30, or COPD]. A specialist consultation and diagnostic sleep study are medically necessary to confirm a diagnosis and determine an appropriate treatment plan.

Provider Information:

Referring Physician: [Doctor Name]

NPI: [NPI Number]

Facility/Clinic: [Practice Name]

Phone: [Phone Number]

Please process this request and provide a determination via fax to [Fax Number]. If additional documentation is required, please contact our office at [Phone Number].

Sincerely,

[Doctor Signature]

[Doctor Printed Name]