[Date]

[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]

RE: Request for Prior Authorization for Vein Mapping Consultation

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to request prior authorization for a vein mapping consultation and diagnostic ultrasound for the above-mentioned patient. This evaluation is medically necessary to assess the patient's venous anatomy in preparation for **[Planned Procedure, e.g., Dialysis Access / Coronary Bypass / Varicose Vein Treatment]**.

Clinical Justification:
The patient presents with **[Diagnosis/ICD-10 Code]**. A detailed vein mapping is required to determine the suitability, diameter, and patency of the vessels to ensure the highest success rate for the upcoming surgical intervention and to minimize postoperative complications.

Requested Services:
- CPT Code: **[93970 or 93971]** - Duplex scan of extremity veins
- CPT Code: **[99203 or 99204]** - Office consultation

Please review this request and provide an authorization number at your earliest convenience. Supporting clinical notes and diagnostic history are attached for your review.

If you require additional information, please contact our office at **[Phone Number]**.

Sincerely,

[Physician Name]
[NPI Number]
[Practice Name]