Date: [Date]

To: [Insurance Company Name / Referral Department]

Fax/Address: [Fax Number or Address]

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Case Reference Number: [Reference Number, if applicable]

Subject: Letter of Medical Necessity for Pre-operative Vein Mapping

To Whom It May Concern,

I am writing to request authorization for a bilateral/unilateral lower and/or upper extremity vein mapping (CPT Code: [Insert Code, e.g., 93970 or 93971]) for the above-referenced patient. This procedure is medically necessary for surgical planning and optimal clinical outcomes.

Clinical Indications:
The patient is currently scheduled for [Name of Surgery, e.g., Coronary Artery Bypass Graft (CABG) / Lower Extremity Bypass / Arteriovenous (AV) Fistula Creation] on [Date of Surgery].

Medical Necessity:
Vein mapping is required to:
1. Evaluate the patency, diameter, and anatomical course of the saphenous or cephalic veins.
2. Identify suitable venous conduits for grafting/fistula creation.
3. Rule out deep vein thrombosis (DVT) or superficial thrombophlebitis that would contraindicate the use of specific vessels.
4. Minimize surgical time and prevent unnecessary surgical incisions in non-viable vessels.

Diagnosis Codes (ICD-10):
- [Insert ICD-10 Code, e.g., I25.10 for Atherosclerotic heart disease]
- [Insert ICD-10 Code, e.g., N18.6 for End-stage renal disease]

Failure to perform this mapping may result in graft failure, increased risk of post-operative complications, or the need for emergency revision surgery.

Please contact my office at [Phone Number] if you require additional clinical documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Practice Name]