[Patient Name]
[Patient Date of Birth]
[Insurance ID Number]
[Group Number]

[Date]

[Insurance Company Name]
[Prior Authorization Department Address]
[City, State, Zip Code]

RE: Request for Pre-Authorization for Reconstructive Evaluation

To Whom It May Concern,

I am writing to request pre-authorization for a reconstructive surgery evaluation for [Patient Name].

Clinical Justification:
The patient requires an evaluation by a specialist to address [Specific Condition, e.g., congenital deformity, post-traumatic injury, or post-mastectomy site]. This consultation is medically necessary to determine the functional impairment caused by the condition and to develop a surgical plan to restore symmetry, function, and/or normal appearance to the affected area.

Provider Information:
Physician Name: [Doctor's Name]
NPI Number: [NPI Number]
Facility Name: [Facility Name]
Tax ID: [Tax ID Number]

CPT/HCPCS Codes for Evaluation:
99203 - 99205 (New Patient Office Visit)

ICD-10 Diagnosis Codes:
[Insert Primary Diagnosis Code, e.g., Q87.0 or C50.911]

Supporting clinical documentation, including [mention any attached records, photos, or previous test results], is enclosed for your review. This evaluation is a necessary step in the treatment of a non-cosmetic, reconstructive nature.

Please provide a determination via fax at [Fax Number] or by mail at your earliest convenience. If you require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Practice Name]