

[Physician Name]  
[Practice Name]  
[Address]  
[City, State, Zip Code]  
[Phone Number]  
[Date]

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

**RE: Letter of Medical Necessity for Positron Emission Tomography (PET) Scan**

**Patient Name:** [Patient Name]  
**Date of Birth:** [DOB]  
**Policy Number:** [Policy ID]  
**Group Number:** [Group Number]  
**Claim/Reference Number:** [Reference Number, if applicable]

To Whom It May Concern,

I am writing to request authorization for a Positron Emission Tomography (PET) scan, typically performed as a PET/CT, for [Patient Name]. This imaging is medically necessary for the initial staging of [Specific Cancer Diagnosis/ICD-10 Code].

**Clinical Background:**

The patient was diagnosed with [Type of Cancer] on [Date] via [Method of Diagnosis, e.g., biopsy]. Initial evaluation including [List previous tests, e.g., CT, MRI, Physical Exam] has [State findings, e.g., indicated a localized tumor but remains inconclusive regarding nodal involvement or distant metastasis].

**Medical Necessity:**

A PET scan is essential at this juncture for the following reasons:

- **Accurate Staging:** To determine the extent of the disease (TNM staging) which cannot be fully characterized by conventional imaging alone.
- **Treatment Planning:** To determine if the patient is a candidate for local curative therapy (surgery/radiation) versus systemic therapy (chemotherapy).
- **Baseline Assessment:** To establish a metabolic baseline for evaluating subsequent response to treatment.

Current NCCN guidelines and clinical standards of care support the use of PET/CT for [Specific Cancer Type] to identify occult metastatic disease that would significantly alter the clinical management of this patient.

Based on the patient's clinical presentation, the PET scan is vital for ensuring the most appropriate and effective treatment strategy is implemented. Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[NPI Number]