

Date: [Date]

To: [Insurance Company Name]

Attention: Utilization Management/Prior Authorization Department

Fax/Address: [Fax Number or Address]

RE: Letter of Medical Necessity for High-Resolution Computed Tomography (HRCT) of the Lungs

Patient Name: [Patient Name]

Date of Birth: [DOB]

Policy Number: [Policy ID]

Group Number: [Group ID]

Claim/Reference Number: [Reference Number, if applicable]

To Whom It May Concern,

I am writing to request authorization for a High-Resolution Computed Tomography (HRCT) of the lungs for the above-mentioned patient. I have determined that this diagnostic imaging is medically necessary to properly manage the patient's pulmonary condition.

Clinical Diagnosis and History:

The patient presents with [List symptoms, e.g., chronic non-productive cough, progressive dyspnea on exertion, unexplained chest pain]. These symptoms have persisted for [Duration]. The current suspected diagnosis is [Suspected Diagnosis, e.g., Interstitial Lung Disease (ILD), Bronchiectasis, or Sarcoidosis].

Medical Necessity:

Standard chest X-rays or conventional CT scans have proven insufficient because [Reason, e.g., results were inconclusive or failed to visualize fine parenchymal detail]. HRCT is required specifically for:

- Evaluation of suspected diffuse interstitial lung disease.
- Characterization of lung parenchyma and small airway disease.
- Monitoring the progression of known pulmonary fibrosis.
- Guiding the location for a potential lung biopsy.

Previous Treatments/Tests:

- [Test 1, e.g., Chest X-Ray]: [Result/Date]
- [Test 2, e.g., Pulmonary Function Tests]: [Result/Date]
- [Trial 1, e.g., Oral Steroids or Inhalers]: [Response/Outcome]

In summary, the HRCT is essential to establish a definitive diagnosis and formulate an appropriate treatment plan. Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]