[Date]

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

RE: Letter of Medical Necessity for Cardiac Magnetic Resonance Imaging (cMRI)

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Policy ID Number: [Policy ID]
Group Number: [Group Number]
Case Reference Number: [Reference Number, if applicable]

To Whom It May Concern,

I am writing on behalf of my patient, **[Patient Name]**, to request formal authorization for a Cardiac Magnetic Resonance Imaging (cMRI) study with contrast to assess myocardial viability (CPT Code: 75561).

Clinical Background:
The patient has a diagnosis of **[Diagnosis, e.g., Ischemic Cardiomyopathy, CAD]** with a recorded Left Ventricular Ejection Fraction (LVEF) of **[Percentage]%**. The patient currently presents with **[Symptoms, e.g., progressive heart failure, exertional dyspnea]**.

Medical Necessity:
A Cardiac MRI is medically necessary for this patient to determine the presence and extent of myocardial viability prior to considering **[Proposed Intervention, e.g., Coronary Artery Bypass Grafting (CABG) or Percutaneous Coronary Intervention (PCI)]**.

Specifically, the cMRI is required to:

- Quantify the transmural extent of scar tissue using Late Gadolinium Enhancement (LGE).
- Distinguish between hibernating myocardium and non-viable infarcted tissue.
- Predict the likelihood of functional recovery following revascularization.

Previous Imaging/Testing:
Previous testing including **[List tests, e.g., Echocardiogram, Stress Test]** performed on **[Date]** was inconclusive regarding the viability of the **[Specify Wall Segment]**.

Cardiac MRI is considered the gold standard for viability assessment. The results of this study are critical to the clinical decision-making process, as revascularization of non-viable tissue carries significant surgical risk without expected functional benefit.

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

Sincerely,

[Physician Signature]

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