[Date]

[Insurance Company Name]
[Attn: Appeals/Medical Review Department]
[Insurance Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Magnetic Resonance Imaging (MRI)
Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Policy Number: [Policy ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number if applicable]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to request authorization for a Magnetic Resonance Imaging (MRI) of the Lumbar Spine (CPT Code: [Insert Code, e.g., 72148]).

Clinical History and Diagnosis:
The patient presents with [Duration, e.g., 6 months] of persistent lumbar pain. The current primary diagnosis is [Diagnosis Name, e.g., Lumbar Radiculopathy/Disc Herniation], ICD-10 code [ICD-10 Code].

Clinical Symptoms and Physical Findings:
[Patient Name] is experiencing the following symptoms:
- [Symptom 1, e.g., Severe lower back pain radiating to left lower extremity]
- [Symptom 2, e.g., Numbness or tingling in the L5/S1 distribution]
- [Symptom 3, e.g., Muscle weakness or diminished reflexes]

Previous Treatments and Failed Conservative Management:
The patient has attempted the following conservative treatments without significant improvement:
- **Physical Therapy:** [Dates/Duration] with [Provider Name].
- **Medications:** [Drug Name, e.g., NSAIDs, Gabapentin, Muscle Relaxants] for [Duration].
- **Injections:** [Type of injection, e.g., Epidural Steroid Injection] performed on [Date].
- **Activity Modification:** Practiced for [Duration].

Rationale for MRI:
An MRI is medically necessary at this time to evaluate the structural integrity of the spinal cord, nerve roots, and intervertebral discs. This imaging is critical to rule out [e.g., high-grade stenosis or cauda equina syndrome] and to guide the next phase of treatment, which may include [e.g., surgical consultation or targeted spinal intervention].

Based on the patient's clinical presentation and failure to respond to conservative therapy, the requested MRI is the most appropriate next step in management.

Please contact my office at [Phone Number] if further information is required.

Sincerely,

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