

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

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

RE: Letter of Medical Necessity for Functional Magnetic Resonance Imaging (fMRI)

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Case/Reference Number: [If applicable]

Dear Medical Director,

I am writing to request authorization and coverage for a Functional Magnetic Resonance Imaging (fMRI) of the brain for the above-referenced patient. This procedure is scheduled to be performed at [Facility Name] on [Date].

Clinical Diagnosis:

The patient has been diagnosed with [Diagnosis, e.g., Brain Tumor, Epilepsy, Vascular Malformation] (ICD-10 Code: [Code]).

Clinical Indications and Rationale:

[Patient Name] is currently undergoing evaluation for [Specific Treatment, e.g., neurosurgical resection]. The fMRI is medically necessary to identify and map eloquent areas of the brain, specifically the [List specific functions, e.g., primary motor cortex, sensory cortex, or language centers], in relation to the [Location of lesion/seizure focus].

Traditional anatomical MRI is insufficient in this case because [Reason, e.g., the lesion is in close proximity to critical functional tissue, and precise mapping is required to minimize post-operative neurological deficits].

Treatment Plan:

The results of this fMRI will be used to:

- Determine the surgical approach and feasibility of resection.
- Maximize the extent of lesion removal while preserving vital brain function.
- Provide essential data for intraoperative navigation and mapping.

In summary, the fMRI is a critical component of this patient's preoperative planning. Failure to perform this study significantly increases the risk of permanent neurological impairment, including loss of [Speech/Motor Skills/Sensation].

Please contact my office at [Phone Number] if you require further clinical documentation or have any questions regarding this request.

Sincerely,

[Physician Signature]
[Physician Name, Title]
[NPI Number]