

[Date]

[Insurance Company Name]
[Claims/Appeals Department Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Advanced Breast MRI

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]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to request authorization and coverage for an Advanced Breast Magnetic Resonance Imaging (MRI) (CPT Code: [Insert Code, e.g., 77048 or 77049]).

Clinical History and Diagnosis:

[Patient Name] is currently under my care for [Diagnosis/Condition, e.g., newly diagnosed breast cancer, high-risk screening, or suspicious clinical findings]. The patient's relevant medical history includes:

- [Insert Clinical Factor 1: e.g., Confirmed BRCA1/BRCA2 mutation]
- [Insert Clinical Factor 2: e.g., Lifetime risk >20% based on Tyrer-Cuzick model]
- [Insert Clinical Factor 3: e.g., Extremely dense breast tissue (BI-RADS Category D)]
- [Insert Clinical Factor 4: e.g., Personal history of chest radiation therapy between ages 10-30]

Medical Necessity:

Conventional imaging, including digital mammography and/or ultrasound, has been [performed/considered] but is insufficient for this patient because:

[Explain why MRI is needed: e.g., "To evaluate the extent of disease in the contralateral breast," "To assess treatment response," or "Due to the limitations of mammography in dense breast tissue for this high-risk individual"].

According to the American College of Radiology (ACR) and American Cancer Society (ACS) guidelines, an MRI is the most sensitive tool for detection and management in patients with this specific clinical profile. Failure to perform this advanced imaging could result in a delayed diagnosis or an incomplete treatment plan.

Conclusion:

Based on the above clinical indicators, I request that you approve coverage for the Breast MRI.

Please contact my office at [Phone Number] if you require further documentation or clinical records.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Practice Name]

[NPI Number]