

Date: [Date]

To: [Insurance Company Name]

Attention: Medical Review/Prior Authorization Department

Address: [Insurance Company Address]

RE: Letter of Medical Necessity for CT Enterography

Patient Name: [Patient Name]

Date of Birth: [DOB]

Policy Number: [Policy ID Number]

Group Number: [Group Number]

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

To Whom It May Concern,

I am writing to request authorization for a **Computed Tomography Enterography (CTE)** (CPT Code: 74177) for the above-referenced patient. I have determined that this procedure is medically necessary to evaluate the patient's gastrointestinal condition.

Clinical Diagnosis:

[Insert Diagnosis, e.g., Crohn's Disease (K50.90), Obscure GI Bleeding (K92.2), or Small Bowel Obstruction]

Clinical Documentation and Rationale:

The patient presents with the following symptoms and history:

[List symptoms, e.g., chronic abdominal pain, weight loss, chronic diarrhea, or unexplained anemia].

Standard imaging and diagnostic tests, including [list previous tests like colonoscopy, ultrasound, or standard CT], have been performed on [Date] with the following results: [Describe results or explain why they were inconclusive].

Reason for CT Enterography:

CTE is required in this case because it provides superior visualization of the small bowel wall, mesenteric vasculature, and perienteric fat compared to standard CT. This specific imaging is essential for:

- [Evaluating the extent and activity of inflammatory bowel disease]
- [Identifying small bowel tumors or polyps]
- [Locating the source of obscure gastrointestinal bleeding]
- [Detecting partial small bowel obstructions]

The information gained from this scan is critical to formulating a treatment plan and avoiding more invasive surgical interventions.

Please contact my office at [Phone Number] if you require additional medical records or clinical notes.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]