[Date]

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

RE: Letter of Medical Necessity for Nuclear Medicine Bone Scintigraphy

Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy ID: [Policy ID]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number (if applicable)]

To Whom It May Concern,

I am writing to request authorization for a Nuclear Medicine Bone Scintigraphy (CPT Code [Insert Code, e.g., 78306]) for the above-mentioned patient. I have determined that this diagnostic procedure is medically necessary to accurately evaluate, diagnose, and manage the patient's current condition.

Clinical History and Diagnosis:
The patient presents with [List primary symptoms, e.g., chronic localized bone pain, suspected fracture, or history of primary malignancy]. The current ICD-10 diagnosis code is [Insert ICD-10 Code].

Medical Justification:
A bone scan is required in this case for the following reasons:
- [Reason 1: e.g., Evaluation of suspected metastatic disease]
- [Reason 2: e.g., Detection of occult fractures not visible on standard X-ray]
- [Reason 3: e.g., Assessment of osteomyelitis or unexplained skeletal pain]

Previous Treatments/Diagnostics:
To date, the following measures have been taken: [List previous tests like X-rays, MRIs, or physical therapy]. These results were [Inconclusive/Negative], necessitating the increased sensitivity of a nuclear bone scan to identify physiological changes at the cellular level.

Based on the patient's clinical presentation, this procedure is the most appropriate next step in their care. Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]

[Practice Name]
[NPI Number]