

[Date]
[Insurance Company Name]
[Prior Authorization Department]
[Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Coronary Computed Tomography Angiography (CCTA)

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

To Whom It May Concern,

I am writing to request authorization for a Coronary Computed Tomography Angiography (CPT Code 75574) for the aforementioned patient. Based on the patient's clinical presentation and medical history, I have determined that this diagnostic procedure is medically necessary to evaluate for coronary artery disease (CAD).

Clinical Indications:

- [Insert primary symptoms, e.g., stable chest pain, atypical angina, or shortness of breath]
- [Insert relevant ICD-10 codes, e.g., R07.9 Chest pain, unspecified]
- [List risk factors, e.g., hypertension, hyperlipidemia, family history of premature CAD, or smoking]

Rationale for CCTA:

The patient currently presents with [Briefly describe clinical scenario, e.g., intermediate pre-test probability of CAD]. A CCTA is required at this time to non-invasively assess the coronary arteries for stenosis, plaque morphology, and anatomical anomalies. This test is essential to guide further management, potentially avoiding the need for more invasive diagnostic procedures such as a Cardiac Catheterization.

Previous Evaluation:

- [Insert results of previous tests, e.g., EKG, Stress Test, or Echocardiogram, or state if these were inconclusive/not feasible]

In summary, the CCTA is the most appropriate and cost-effective next step for this patient's cardiovascular evaluation. I request that you approve this request promptly to ensure the patient receives the necessary standard of care.

Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]