

Date: [Date]

To: [Insurance Company Name]

Attn: [Prior Authorization/Appeals Department]

Fax/Address: [Fax Number or Address]

Patient Name: [Patient Name]

Patient Date of Birth: [DOB]

Policy Number: [Policy ID]

Group Number: [Group ID]

Case Reference Number: [Reference Number, if applicable]

Subject: Letter of Medical Necessity for Advanced Fetal Magnetic Resonance Imaging (CPT 74712/74713)

To Whom It May Concern,

I am writing to request authorization for an Advanced Fetal Magnetic Resonance Imaging (MRI) for my patient, [Patient Name], who is currently at [Number] weeks of gestation. This procedure is medically necessary to further evaluate fetal anomalies identified during a screening ultrasound.

Clinical History and Findings:

On [Date], a fetal ultrasound revealed the following suspicious findings: [Describe specific findings, e.g., ventriculomegaly, suspected diaphragmatic hernia, or complex cardiac defect]. Due to the limitations of ultrasound imaging, including [maternal habitus, fetal position, or decreased amniotic fluid], a definitive diagnosis and prognosis cannot be established based on ultrasound alone.

Medical Necessity:

Fetal MRI is required in this case for the following reasons:

- To provide superior soft-tissue contrast and a larger field of view to characterize [specific organ system].
- To confirm or rule out associated anomalies that may change the course of prenatal care.
- To assist in delivery planning and determine the need for immediate neonatal surgical intervention at a tertiary care center.
- To provide the multidisciplinary team (Maternal-Fetal Medicine, Neonatology, and Pediatric Surgery) with necessary data for family counseling.

Conclusion:

In summary, the fetal MRI is essential for the clinical management of this high-risk pregnancy. Failure to perform this imaging may result in an incomplete diagnosis and suboptimal perinatal care. I request that you approve this request for CPT code(s): [74712 and 74713 if applicable].

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

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Practice/Hospital Name]

[NPI Number]