Date: [Date]

To: [Insurance Company Name]
Prior Authorization Department
Fax/Address: [Fax Number or Address]

RE: Initial Prior Authorization Request for MRI Lumbar Spine

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Group Number: [Group Number]
Case/Reference Number: [If applicable]

Provider Information:
Requesting Provider: [Physician Name]
NPI Number: [NPI Number]
Phone: [Phone Number]
Fax: [Fax Number]

Requested Procedure: MRI Lumbar Spine (CPT: 72148)
Diagnosis: [Diagnosis Name and ICD-10 Code]

Clinical Justification:

The patient presents with [Duration] of low back pain associated with [List symptoms: e.g., radiculopathy, numbness, weakness]. Physical examination reveals [List findings: e.g., positive straight leg raise, decreased reflexes, or motor deficit].

Conservative Treatment History:
The patient has completed the following treatments without significant improvement:

- **Physical Therapy:** [Dates/Duration]
- **Medications:** [NSAIDs/Muscle Relaxants/Analgesics used and duration]
- **Home Exercise Program:** [Duration]
- **Other:** [e.g., Epidural steroid injections or Specialist consultations]

Necessity:
An MRI is medically necessary at this time to evaluate for [e.g., disc herniation, spinal stenosis, or nerve root compression] and to guide further surgical or interventional treatment planning.

Please find the attached clinical notes, physical therapy reports, and relevant imaging for your review. If you require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]