**[Date]**

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

**RE: Initial Prior Authorization Request for CT Abdomen and Pelvis**

**Patient Name:** [Patient First and Last Name]
**Date of Birth:** [MM/DD/YYYY]
**Member ID:** [Insurance ID Number]
**Group Number:** [Group Number]
**Case/Reference Number:** [If applicable]

To Whom It May Concern,

I am writing to request prior authorization for a **CT Scan of the Abdomen and Pelvis [with/without/with and without] contrast** (CPT Code: [Insert Code, e.g., 74176, 74177, or 74178]) for the above-referenced patient.

**Clinical Indication/Diagnosis:**
The patient presents with [Primary Diagnosis/Symptoms, e.g., chronic right lower quadrant pain, suspected malignancy, or inflammatory bowel disease]. The ICD-10 code for this condition is [Insert Code].

**Medical Necessity:**
This imaging study is medically necessary because:
- [Reason 1: e.g., Failure of conservative treatment (list medications/durations)]
- [Reason 2: e.g., Abnormal physical exam findings or lab results]
- [Reason 3: e.g., Need for surgical planning or staging]

**Previous Interventions:**
The patient has previously undergone the following (if applicable):
- [Previous Imaging/X-rays/Ultrasounds and dates]
- [Relevant Lab Work results]
- [Previous Medications/Treatments tried]

A CT scan is required at this time to establish an accurate diagnosis and determine the appropriate course of treatment. Detailed clinical notes and supporting documentation are attached for your review.

Please contact my office at [Phone Number] or via fax at [Fax Number] if further information is required. Thank you for your prompt attention to this request.

Sincerely,

**[Physician Name, MD/DO]**
**[NPI Number]**
**[Practice Name]**