Date: [Date]

TO: [Insurance Company Name]
ATTN: Prior Authorization Department
FAX: [Fax Number]
PHONE: [Phone Number]

RE: Initial Prior Authorization Request for PET/CT Scan

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member 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 **PET/CT Scan (CPT Code: 78815)** for the above-referenced patient. This imaging is medically necessary for the **initial staging** of the patient's recently diagnosed malignancy.

Clinical Documentation:

- **Diagnosis:** [Specific Cancer Type, e.g., Non-Small Cell Lung Cancer]
- **ICD-10 Code:** [Insert ICD-10 Code]
- **Date of Diagnosis:** [Date]
- **Method of Diagnosis:** [e.g., Biopsy, Pathology Report dated MM/DD/YYYY]

Medical Necessity:

The patient has been diagnosed with a malignancy that requires accurate metabolic staging to determine the extent of the disease (TNM staging). A PET/CT scan is essential at this time to:
- Detect potential distant metastasis not visible on standard CT/MRI.
- Identify nodal involvement to guide surgical intervention or radiation fields.
- Establish a baseline for assessing future treatment response.

Failure to perform this scan may lead to suboptimal treatment planning, unnecessary surgical procedures, or delayed systemic therapy.

Provider Information:

Ordering Physician: [Physician Name]
NPI Number: [NPI Number]
Facility Name: [Facility Name for Scan]
Tax ID: [Facility Tax ID]

Attached please find the relevant pathology reports and clinical notes. Should you require additional information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, Title]
[Practice Name]