Date: [Date]
To: [Insurance Company Name]
Fax Number: [Insurance Fax Number]
From: [Provider Name/Clinic Name]
Subject: Initial Prior Authorization Request for MRI Brain With Contrast

PATIENT INFORMATION:

- **Patient Name:** [Patient Name]
- **Date of Birth:** [DOB]
- **Member ID:** [Member ID Number]
- **Group Number:** [Group Number]

REQUEST DETAILS:

- **Requested Procedure:** MRI Brain With Contrast
- **CPT Code:** 70552
- **Diagnosis Code(s):** [ICD-10 Code, e.g., G44.0]
- **Place of Service:** [Outpatient Hospital/Imaging Center]

CLINICAL JUSTIFICATION:

The patient presents with [List primary symptoms, e.g., chronic headaches, focal neurological deficits, or suspected neoplasm]. Symptoms have persisted for [Duration].

Previous Treatments/Studies:

- [List failed medications or conservative treatments]
- [List results of previous imaging, e.g., CT scan or non-contrast MRI]
- [List physical exam findings]

An MRI with contrast is medically necessary at this time to [Reason for contrast, e.g., evaluate for blood-brain barrier breakdown, characterize a lesion, or assess inflammatory processes].

Please review this request for medical necessity. If you require additional documentation, please contact our office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, Title]
[NPI Number]
[Contact Phone/Fax]