Date: [Date]

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

RE: Initial Prior Authorization Request for CT Angiography (CTA) Chest

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 Physician: [Physician Name]
NPI Number: [NPI Number]
Phone Number: [Phone Number]
Fax Number: [Fax Number]

Clinical Documentation:

Requested Procedure: CT Angiography (CTA) Chest (CPT Code: 71275)
Requested Facility: [Facility Name]
Diagnosis Code(s): [ICD-10 Code, e.g., I33.0, R06.02]

Clinical Justification:

The patient presents with [List primary symptoms, e.g., acute chest pain, shortness of breath, suspected pulmonary embolism]. The CTA of the chest is medically necessary for this patient to [Reason for scan, e.g., evaluate the pulmonary arteries, assess for aortic aneurysm, or rule out vascular abnormalities].

Relevant History:

- [Previous imaging results or diagnostic tests]
- [Relevant lab results, e.g., elevated D-Dimer]
- [Failed conservative treatments or medications, if applicable]

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

Sincerely,

[Physician Signature]
[Physician Name, Title]