Date: [Date]

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

RE: Initial Prior Authorization Request for Musculoskeletal MRI

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

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

Requested Procedure:
CPT Code: 73221 (MRI Upper Extremity Any Joint Without Contrast) OR 73721 (MRI Lower Extremity Any Joint Without Contrast - Right Knee)
ICD-10 Code(s): [e.g., M23.20 Right Knee Internal Derangement]

Clinical Justification:

The patient presents with [Duration, e.g., 6 weeks] of right knee pain following [Mechanism of injury or onset]. Symptoms include [Symptoms: e.g., swelling, locking, instability, or inability to weight bear].

Conservative Treatments Completed:

- Physical Therapy: [Dates or Duration]
- Medications: [e.g., NSAIDs, Steroids]
- Activity Modification: [Details]
- Previous Imaging: [e.g., X-rays dated MM/DD/YYYY showing...]

The requested MRI is medically necessary to evaluate for [e.g., meniscus tear, ACL/ligamentous injury, or osteochondral defect] and to determine the future surgical or non-surgical course of treatment.

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

Sincerely,

[Physician Signature]
[Physician Printed Name]