Date: [Date]

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

RE: Initial Prior Authorization Request

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Group Number: [Group Number]
Case/Reference Number (if applicable): [Reference Number]

Requested Procedure: Nuclear Medicine Bone Scan (Whole Body)
CPT Code: 78306 (or [Insert Specific CPT Code])
Diagnosis Code(s): [ICD-10 Code, e.g., C61 for Prostate Cancer]

To Whom It May Concern,

I am writing to request prior authorization for a Nuclear Medicine Bone Scan for the patient listed above. This study is medically necessary to [Reason: e.g., evaluate the extent of metastatic disease, investigate unexplained bone pain, or monitor response to therapy].

Clinical Justification:

- **Patient History:** [Brief summary of diagnosis and clinical progression].
- **Physical Findings:** [Localized pain, tenderness, or specific symptoms].
- **Previous Imaging/Labs:** [List relevant X-rays, CT scans, or elevated PSA/Alkaline Phosphatase levels].
- **Treatment Plan:** The results of this bone scan are required to determine the appropriate course of treatment and management for this patient.

I have attached the relevant clinical notes, pathology reports, and laboratory results to support this request. If you require additional information, please contact my office at [Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Physician Name]
[NPI Number]
[Practice Name]
[Phone Number]