[Date]

To: [Insurance Company Name]
Attn: Prior Authorization Department
Fax/Address: [Fax Number or Address]

RE: Initial Prior Authorization Request for Breast MRI (CPT 77049)

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

To Whom It May Concern,

I am writing to request prior authorization for a screening Breast MRI with and without contrast for the above-referenced patient. This patient has been identified as being at high risk for breast cancer and requires supplemental screening in addition to annual mammography.

Clinical Documentation for High-Risk Status:

- **Lifetime Risk Score:** [Insert Percentage, e.g., 22%] as calculated by the [Insert Model Name, e.g., Tyrer-Cuzick or Gail Model].
- **Genetic Factors:** [Specify, e.g., Positive BRCA1/BRCA2 mutation or first-degree relative with known mutation].
- **Personal/Family History:** [Briefly describe relevant history, e.g., Mother diagnosed with pre-menopausal breast cancer].
- **Breast Density:** The patient has [Insert Density, e.g., Extremely Dense] breast tissue, which limits the sensitivity of standard mammography.

Annual screening Breast MRI is recommended for this patient based on guidelines from the American College of Radiology (ACR) and the American Cancer Society (ACS) for individuals with a lifetime risk of 20% or greater.

Included with this letter are the patient's clinical notes and risk assessment results. Please process this request as soon as possible so the patient may proceed with this necessary preventative screening.

Sincerely,

[Physician Name]
[NPI Number]
[Facility Name]
[Phone Number]