Date: [Date]

To: [Health Insurance Company Name]
Attention: Utilization Management/Prior Authorization Department
Fax/Address: [Fax Number or Mailing Address]

RE: Initial Prior Authorization Request for MRA Head and Neck

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

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

Requested Procedure:
CPT Code: [e.g., 70544, 70547, 70549]
Description: Magnetic Resonance Angiography (MRA) of the Head and Neck
Place of Service: [Inpatient/Outpatient/Imaging Center]

Clinical Documentation:

Diagnosis Codes (ICD-10):
1. [Primary ICD-10 Code]
2. [Secondary ICD-10 Code]

Clinical Indications:
[Provide brief summary of symptoms, e.g., TIA, stroke, carotid stenosis, aneurysm screening, or pulsatile tinnitus.]

Relevant History:
[List previous imaging results, physical exam findings, or failed conservative treatments.]

Medical Necessity Statement:
This procedure is medically necessary to further evaluate [Condition] and to guide the treatment plan for this patient. The requested MRA is the most appropriate diagnostic tool to visualize the vascular structures of the head and neck in this clinical context.

Thank you for your prompt attention to this request. If you require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]