Date: [Date]

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

RE: Initial Prior Authorization Request for Functional MRI (fMRI)

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Policy ID: [Member ID Number]
Group Number: [Group Number]
Case Reference Number: [Reference Number, if applicable]

Dear Prior Authorization Department,

I am writing to request a prior authorization for a functional Magnetic Resonance Imaging (fMRI) for the above-referenced patient. This diagnostic procedure is medically necessary for the preoperative neurological assessment and surgical planning for [Patient Name].

Clinical Indication:
The patient has been diagnosed with [Primary Diagnosis, e.g., Intractable Epilepsy, Brain Tumor, or Vascular Malformation] (ICD-10 Code: [Code]).

Medical Necessity:
An fMRI is required to identify and map eloquent areas of the brain, including motor, sensory, and language cortex, in relation to the [Lesion/Seizure Focus]. This information is critical to:

- Minimize the risk of permanent neurological deficits during surgical intervention.
- Determine the feasibility of surgical resection.
- Provide precise guidance for neuronavigation systems during the procedure.

Requested Procedure:
CPT Code: [e.g., 70554 or 70555]
Description: Magnetic resonance imaging, brain, functional MRI; [select: including/excluding physician administration of task]

Requested Provider/Facility:
Facility Name: [Facility Name]
Tax ID/NPI: [Provider NPI]

Enclosed please find clinical notes, previous imaging reports (MRI/CT), and relevant neurological evaluations supporting this request. Please contact my office at [Phone Number] if further information is required.

Thank you for your prompt attention to this matter.

Sincerely,

[Physician Name]
[Physician Title/Specialty]
[NPI Number]
[Contact Information/Clinic Name]