Date: [Date]

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

RE: Initial Prior Authorization Request for Elective Total Knee Arthroplasty

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [ID Number]
Group Number: [Group Number]
Provider Case/Reference Number: [Optional Number]

Dear Medical Reviewer,

I am writing to request prior authorization for an elective **Total Knee Arthroplasty (CPT 27447)** for the above-referenced patient. The procedure is scheduled for [Date] at [Facility Name].

Clinical Documentation Summary:

- **Diagnosis:** [e.g., Advanced Osteoarthritis of the Left/Right Knee - ICD-10 Code]
- **Symptoms:** The patient reports chronic, severe pain that limits activities of daily living (ADLs), including walking, climbing stairs, and [Other functional limitations].
- **Physical Exam Findings:** [e.g., Decreased range of motion, crepitus, joint line tenderness, or deformity].
- **Radiographic Evidence:** Imaging dated [Date] demonstrates [e.g., Joint space narrowing, osteophytes, or subchondral sclerosis].
- **Failed Conservative Treatments:** The patient has completed a minimum of [Number] months of conservative therapy without significant relief, including:
    - [e.g., Physical Therapy from Date to Date]
    - [e.g., Use of NSAIDs or other analgesics]
    - [e.g., Intra-articular injections - steroid or hyaluronic acid]
    - [e.g., Weight loss or activity modification]

Based on the failure of non-surgical management and the severity of the patient's functional impairment, I have determined that Total Knee Arthroplasty is medically necessary.

Please find the attached office notes, physical therapy reports, and radiology reports supporting this request. Should you require additional information, please contact my office at [Phone Number].

Sincerely,

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