Date: [Date]
To: [Insurance Company Name]
Attention: Prior Authorization Department
Fax/Email: [Fax Number or Email Address]

RE: Initial Prior Authorization Request for Elective Cataract Surgery

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

To Whom It May Concern,

I am writing to request prior authorization for elective cataract extraction surgery for the patient listed above. Based on clinical evaluation, the patient has a hemodynamically significant cataract that interferes with activities of daily living.

Clinical Information:

- **Diagnosis:** [e.g., Age-related nuclear cataract, right eye]
- **ICD-10 Code:** [Insert Code, e.g., H25.11]
- **Procedure:** Extracapsular cataract removal with insertion of intraocular lens (CPT 66984)
- **Eye:** [Right Eye / Left Eye / Both]
- **Best Corrected Visual Acuity:** [e.g., 20/50]

Medical Necessity:
The patient reports difficulty with [e.g., driving at night, reading small print, or glare]. Conservative treatment with updated spectacle prescription no longer provides functional vision. The surgery is scheduled for [Date] at [Facility Name].

Please find the attached clinical notes, visual acuity tests, and dilated fundus exam results for your review. If you require additional information, please contact our office at [Phone Number].

Sincerely,

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