

DATE: [Date]

TO: [Insurance Company Name]

ATTN: Prior Authorization Department

FAX: [Fax Number]

RE: Initial Prior Authorization Request for Elective Lumbar Spinal Fusion

PATIENT INFORMATION:

Name: [Patient Name]

Date of Birth: [DOB]

Member ID: [ID Number]

Group Number: [Group Number]

PROVIDER INFORMATION:

Requesting Surgeon: [Surgeon Name]

NPI: [NPI Number]

Facility Name: [Hospital/Surgical Center Name]

CLINICAL DETAILS:

Diagnosis: [e.g., Degenerative Spondylolisthesis / Spinal Stenosis]

ICD-10 Code: [Code]

Procedure: [e.g., Posterior Lumbar Interbody Fusion (PLIF)]

CPT Codes: [List CPT Codes, e.g., 22633, 22840, 22853]

Proposed Date of Service: [Date]

MEDICAL NECESSITY SUMMARY:

The patient presents with chronic low back pain and [radiculopathy/neurogenic claudication] that has persisted for [Number] months/years. Symptoms significantly limit activities of daily living and have failed to respond to conservative management.

CONSERVATIVE TREATMENT HISTORY:

- Physical Therapy: [Dates/Duration]
- Medications: [NSAIDs/Muscle Relaxants/Gabapentin]
- Injections: [Epidural Steroid Injections/Facet Blocks and Dates]
- Home Exercise Program: [Duration]

IMAGING FINDINGS:

- [Date] MRI/CT: Shows [Describe findings, e.g., severe disc space narrowing, instability at L4-L5].

REQUEST:

Based on the attached clinical notes, imaging reports, and failure of conservative therapy, I am requesting prior authorization for the elective lumbar spinal fusion listed above. This procedure is medically necessary to stabilize the spine and alleviate debilitating neurological symptoms.

Sincerely,

[Surgeon Signature]

[Surgeon Name]

[Phone Number]