

**Date:** [Date]

**To:** [Insurance Company Name]

**Attention:** Prior Authorization Department

**Fax/Link:** [Fax Number or Portal ID]

**RE: Initial Prior Authorization Request for Elective Inguinal Hernia Repair**

**Patient Information:**

Name: [Patient Name]

Date of Birth: [DOB]

Member ID: [ID Number]

Group Number: [Group Number]

**Provider Information:**

Requesting Physician: [Surgeon Name]

NPI Number: [NPI Number]

Facility Name: [Hospital/Surgery Center Name]

Tax ID: [Tax ID]

**Clinical Information:**

Diagnosis: Inguinal Hernia (ICD-10 Code: [Insert Code, e.g., K40.90])

Proposed Procedure: [Insert Procedure, e.g., Laparoscopic Inguinal Hernia Repair]

CPT Code(s): [Insert Code, e.g., 49650]

Proposed Date of Service: [Date]

**Clinical Summary:**

The patient presents with a symptomatic inguinal hernia. Clinical findings include [mention symptoms, e.g., persistent pain, bulge, discomfort during physical activity]. Physical examination confirmed the presence of [Left/Right/Bilateral] inguinal hernia.

**Medical Necessity:**

Surgical intervention is medically necessary to alleviate symptoms and prevent future complications such as incarceration or strangulation. Conservative management has been considered, but definitive surgical repair is the recommended standard of care for this symptomatic patient.

Please find attached supporting clinical notes and physical examination records. We request an expedited review of this authorization.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Contact Phone Number]