DATE: [Insert Date]

TO: [Insurance Company Name]
ATTN: Prior Authorization Department
FAX/PORTAL: [Insert Fax Number or Submission Method]

RE: Initial Prior Authorization Request for Elective Surgery

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

PROVIDER INFORMATION:
Requesting Surgeon: [Surgeon Name]
NPI: [Surgeon NPI]
Facility Name: [Hospital or Surgery Center Name]
Tax ID: [Facility Tax ID]

CLINICAL DETAILS:
Procedure Code (CPT): 64721 (Neuroplasty and/or transposition; median nerve at carpal tunnel)
Diagnosis Code (ICD-10): G56.01 (Carpal tunnel syndrome, right upper limb) or G56.02 (Carpal tunnel syndrome, left upper limb)
Proposed Date of Service: [Insert Date]

CLINICAL JUSTIFICATION:
The patient has been diagnosed with symptomatic Carpal Tunnel Syndrome. Clinical documentation is attached confirming the following:

- Symptoms including pain, paresthesia, or numbness in the median nerve distribution.
- Positive physical exam findings (e.g., Tinel's sign, Phalen's test, or thenar atrophy).
- Failure of conservative treatments, including [list: e.g., wrist splinting, NSAIDs, or activity modification] for a period of [X] months.
- Electromyography (EMG) and Nerve Conduction Study (NCS) results confirming median neuropathy at the wrist (Results attached).

We are requesting approval for this elective procedure to alleviate symptoms and prevent permanent nerve damage. Please contact our office at [Phone Number] if further information is required.

Sincerely,

[Surgeon Name/Signature]
[Practice Name]

ATTACHMENTS: Clinical Notes, EMG/NCS Reports, Conservative Treatment History.