

Date: [Date]

TO: [Insurance Company Name]

ATTN: Prior Authorization Department

FAX: [Fax Number]

RE: Initial Prior Authorization Request for Elective Surgery

Patient Name: [Patient Name]

Date of Birth: [DOB]

Member ID: [Member ID Number]

Group Number: [Group Number]

Dear Prior Authorization Department,

I am writing to request prior authorization for an elective **Laparoscopic Cholecystectomy** for the above-referenced patient. This procedure is medically necessary to treat [Diagnosis, e.g., Symptomatic Cholelithiasis / Chronic Cholecystitis].

Clinical Details:

- **Diagnosis Code (ICD-10):** [ICD-10 Code]
- **Procedure Code (CPT):** 47562 (Laparoscopic Cholecystectomy)
- **Anticipated Date of Service:** [Date]
- **Facility Name:** [Facility Name]

Clinical Justification:

The patient presents with [List symptoms, e.g., recurrent biliary colic, nausea, and fatty food intolerance]. Diagnostic imaging ([Type of scan, e.g., Ultrasound]) performed on [Date] confirmed the presence of [Findings, e.g., gallstones/thickened gallbladder wall]. Conservative management has failed to alleviate the symptoms, and surgical intervention is now required to prevent further biliary complications.

Please find the attached clinical notes, imaging reports, and relevant lab results for your review. If you require additional information, please contact my office at [Phone Number].

Thank you for your prompt attention to this request.

Sincerely,

[Physician Name]

[NPI Number]

[Practice Name]

[Phone Number]