DATE: [Date]

TO: [Insurance Company Name]
ATTN: Prior Authorization Department
FAX/ADDRESS: [Fax Number or Mailing Address]

RE: Initial Prior Authorization Request for Elective Breast Reconstruction

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

PROVIDER INFORMATION:
Requesting Physician: [Surgeon Name]
NPI Number: [Provider NPI]
Tax ID: [Tax ID]
Contact Number: [Phone Number]

CLINICAL DETAILS:
Diagnosis Code(s): [ICD-10 Code, e.g., C50.911 or Z85.3]
Diagnosis Description: [e.g., Malignant neoplasm of breast or Personal history of malignant neoplasm of breast]
Procedure Code(s) (CPT): [e.g., 19367, 19357, 19342]
Procedure Description: [e.g., Breast reconstruction with TRAM flap, Tissue Expander Placement, etc.]
Proposed Date of Surgery: [Date]

To Whom It May Concern,

I am writing to request prior authorization for breast reconstruction surgery for the above-referenced patient. This procedure is being performed in accordance with the Women's Health and Cancer Rights Act (WHCRA) of 1998, which mandates coverage for breast reconstruction following a mastectomy.

The patient has been diagnosed with [Diagnosis] and [is undergoing/has undergone] a [Type of Mastectomy]. Breast reconstruction is a standard part of the treatment plan to restore symmetry and function. Attached you will find clinical notes, pathology reports, and the surgical plan supporting the medical necessity of this procedure.

Please provide a determination regarding this authorization request within the standard timeframe. If you require further information, please contact my office at [Phone Number].

Sincerely,

[Surgeon Signature]
[Surgeon Printed Name]
[Facility Name]

ENCLOSURES:
1. Clinical Progress Notes
2. Pathology Report
3. Mastectomy Operative Report (if applicable)
4. Photographs (if required by carrier)