Date: [Date]
To: [Insurance Company Name]
Attention: Prior Authorization Department / Medical Review
Fax/Address: [Fax Number or Address]

RE: INITIAL PRIOR AUTHORIZATION REQUEST

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Case Reference Number: [If applicable]

PROVIDER INFORMATION:

Requesting Physician: [Physician Name]
NPI Number: [NPI Number]
Facility Name: [Hospital or Surgery Center Name]
Tax ID / NPI: [Facility ID]
Contact Person: [Name] | **Phone:** [Phone Number]

CLINICAL INFORMATION:

Proposed Procedure: Elective Endoscopic Sinus Surgery (FESS)
CPT Codes: [e.g., 31255, 31267, 31276]
ICD-10 Diagnosis Codes: [e.g., J32.0 Chronic Maxillary Sinusitis]
Requested Date of Service: [Date]

CLINICAL JUSTIFICATION:

The patient has been diagnosed with chronic rhinosinusitis that has been refractory to medical management. Symptoms include [List symptoms: e.g., nasal obstruction, facial pain, purulent discharge] lasting for [Duration] months.

Conservative Treatments Attempted:

- **Antibiotics:** [Drug Name], [Duration], [Results]
- **Intranasal Steroids:** [Drug Name], [Duration], [Results]
- **Saline Irrigations:** [Frequency/Duration]
- **Oral Steroids:** [If applicable, list details]

Objective Findings:

A CT scan of the paranasal sinuses performed on [Date] demonstrates [Briefly describe findings, e.g., mucosal thickening, opacification of the osteomeatal complex, or anatomical abnormalities]. Physical examination and nasal endoscopy confirm [Findings].

Based on the patient's persistent symptoms and failure of maximum medical therapy, surgery is medically necessary to restore sinus drainage and improve quality of life.

Please review this request for medical necessity. Supporting documentation, including office notes and imaging reports, are attached. If you require further information, please contact our office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Practice Name]