Date: [Insert Date]

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

RE: Initial Prior Authorization Request for Elective Total Hip Replacement

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insert ID Number]
Group Number: [Insert Group Number]

To Whom It May Concern,

I am writing to request prior authorization for an elective Total Hip Arthroplasty (CPT Code: 27130) for the above-referenced patient. This procedure is scheduled for [Date of Surgery] at [Facility Name].

Clinical Diagnosis: [e.g., Severe Osteoarthritis of the Right/Left Hip]
ICD-10 Code: [Insert ICD-10 Code, e.g., M16.11]

Clinical Justification:
The patient presents with chronic hip pain and significant functional limitations. The following medical necessity criteria have been met:

- **Radiographic Evidence:** Imaging dated [Date] shows [e.g., joint space narrowing, subchondral sclerosis, or osteophyte formation].
- **Conservative Treatment:** The patient has completed [Number] months of conservative therapy, including [e.g., physical therapy, NSAIDs, activity modification, or injections], without adequate relief.
- **Functional Impact:** The patient experiences difficulty with activities of daily living (ADLs), such as walking, climbing stairs, and [Insert other limitation].

Enclosed please find the following supporting documentation:

- Recent orthopedic consultation notes
- Radiology reports (X-ray/MRI)
- Physical therapy records or conservative management logs

Please review this request for medical necessity. If you require additional information, please contact my office at [Phone Number]. Thank you for your prompt attention to this matter.

Sincerely,

[Provider Name]
[NPI Number]
[Practice Name]
[Contact Phone/Fax]