

Date: [Date]

To: [Insurance Company Name]

Attn: Prior Authorization Department

Fax/Address: [Fax Number or Mailing Address]

RE: Initial Prior Authorization Request for Elective Septoplasty

Patient Information:

Name: [Patient Name]

Date of Birth: [DOB]

Member ID: [ID Number]

Group Number: [Group Number]

Provider Information:

Ordering Physician: [Doctor Name]

NPI Number: [NPI Number]

Facility Name: [Hospital or Surgery Center Name]

Tax ID: [Tax ID Number]

Clinical Information:

Requested Procedure: Septoplasty

CPT Code: 30520

ICD-10 Code: [e.g., J34.2 - Deviated Nasal Septum]

Scheduled Date of Service: [Date]

To Whom It May Concern,

I am writing to request prior authorization for a septoplasty for the above-referenced patient. This procedure is medically necessary to treat a symptomatic deviated septum that has caused significant nasal airway obstruction.

The patient presents with the following symptoms and history:

- Chronic nasal congestion and difficulty breathing through the nose.
- Physical examination confirming significant septal deviation to the [Left/Right/Both] side(s).
- Failure of conservative medical management, including [List treatments, e.g., nasal steroids, antihistamines, or decongestants] for a period of [Number] weeks/months.
- [Optional: Mention sleep apnea, recurrent sinusitis, or epistaxis if applicable].

Attached please find the clinical notes, physical examination findings, and [Optional: CT scan reports/Endoscopy reports] supporting this request.

Thank you for your prompt attention to this matter. Please contact my office at [Phone Number] should you require further information.

Sincerely,

[Physician Signature]

[Physician Printed Name]