[Date]

[Insurance Company Name]
[Prior Authorization Department]
[Address]
[City, State, Zip Code]
[Fax Number]

RE: Initial Prior Authorization Request for Custom Power Wheelchair
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Provider Tax ID: [Tax ID]

To Whom It May Concern,

I am writing to formally request prior authorization for a custom power wheelchair (HCPCS Code: [Insert Code, e.g., K0848-K0861]) and associated custom seating components for the above-referenced patient. This equipment is medically necessary to manage the patient's mobility limitations and support activities of daily living (ADLs).

Clinical Diagnosis:
[Insert Primary Diagnosis, e.g., Multiple Sclerosis, Spinal Cord Injury, Muscular Dystrophy] (ICD-10: [Insert Code])

Medical Necessity Justification:
The patient presents with [list physical impairments, e.g., non-functional ambulation, poor trunk control, inability to self-propel a manual wheelchair]. A standard power wheelchair is insufficient because the patient requires [list custom features, e.g., power tilt-in-space for pressure relief, custom contoured seating for postural support, or specialized joystick controls]. Without this equipment, the patient is at high risk for [list risks, e.g., skin breakdown, falls, or further musculoskeletal deformity].

Included Documentation:

- Physician's Written Order/Prescription
- Specialty Evaluation by Physical/Occupational Therapist (ATP Evaluated)
- Detailed Itemized List of Components (Quote)
- Clinical Progress Notes

Please review the attached documentation for a complete clinical picture. If further information is required, please contact my office at [Phone Number]. We look forward to a timely response regarding this request.

Sincerely,

[Physician Name/Signature]
[NPI Number]
[Clinic/Facility Name]
[Phone Number]