[Date]

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

RE: Prior Authorization Request for Semi-Electric Hospital Bed (HCPCS E0260)

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Provider NPI: [Doctor NPI Number]

To Whom It May Concern,

I am writing to request prior authorization for a semi-electric hospital bed for my patient, [Patient Name]. This equipment is medically necessary for the management of the patient's condition: [Primary Diagnosis/ICD-10 Code].

The patient meets the medical necessity criteria for a semi-electric hospital bed due to the following clinical indications:

- The patient requires frequent changes in body position to alleviate pain and/or prevent skin breakdown.
- The patient requires the head of the bed to be elevated more than 30 degrees due to [Condition, e.g., CHF, COPD, aspiration risk].
- The patient requires a bed height that can be adjusted to permit safe transfers to a chair, wheelchair, or standing position.
- The patient's condition requires positioning of the body in ways not feasible with an ordinary bed.

Traditional pillows and wedges have been tried and are insufficient to meet the patient's clinical needs. The semi-electric features are essential to allow the patient to adjust the head and knee sections independently to maintain physiological stability and safety.

Accompanying this letter, please find the clinical documentation, including office visit notes and a formal prescription. Please contact my office at [Phone Number] if you require additional information.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Clinic/Practice Name]
[Phone Number]
[Fax Number]