Date: [Date]

TO: [Health Insurance Company Name]
ATTN: Prior Authorization Department
FAX: [Fax Number]

RE: Initial Prior Authorization Request for Negative Pressure Wound Therapy (NPWT)

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [ID Number]
Policy/Group Number: [Group Number]

Dear Medical Review Department,

I am writing to request prior authorization for a Negative Pressure Wound Therapy (NPWT) pump and related supplies for the above-referenced patient. This treatment is medically necessary based on the clinical documentation provided.

Clinical Diagnosis and Wound Information:

- **ICD-10 Code(s):** [Insert Codes]
- **Wound Type:** [e.g., Chronic Stage IV Pressure Ulcer, Dehisced Surgical Wound]
- **Wound Location:** [Insert Location]
- **Wound Measurements:** Length: [cm], Width: [cm], Depth: [cm]

Treatment History:

The patient has undergone at least 30 days of conventional wound care without significant healing. Conventional therapy included: [e.g., moisture-retentive dressings, debridement, nutrition management, and pressure relief].

Medical Necessity:

NPWT is required to promote granulation tissue formation, manage heavy exudate, and facilitate wound closure. The patient is expected to follow the prescribed therapy for [Insert Duration, e.g., 4 weeks].

Requested Equipment/Supplies:

- HCPCS E2402: NPWT Pump (Rental)
- HCPCS A6550: NPWT Dressing Kits ([Number] per month)
- HCPCS A7000: Canisters ([Number] per month)

Please find the attached clinical notes, wound logs, and photographs for your review. If you have any questions, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Facility Name]