Date: [Date]

To: [Insurance Company Name]
Attention: Utilization Management/Prior Authorization Department
Fax/Address: [Fax Number or Address]

RE: Initial Prior Authorization Request for Osteogenesis Bone Growth Stimulator

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

Provider Information:
Physician Name: [Ordering Physician Name]
NPI Number: [NPI Number]
Clinic/Hospital: [Facility Name]
Phone/Fax: [Phone and Fax Numbers]

Request Details:
HCPCS Code Requested: [e.g., E0747 or E0748]
Diagnosis Code (ICD-10): [e.g., M84.18XA - Nonunion of fracture]
Type of Device: [Ultrasonic or Electromagnetic] Bone Growth Stimulator

Clinical Justification:

Dear Medical Reviewer,

I am writing to request prior authorization for an Osteogenesis Bone Growth Stimulator for the patient listed above. This patient has been diagnosed with [Specific Diagnosis/Nonunion/Delayed Union] of the [Specific Bone/Location].

The patient meets the medical necessity criteria based on the following clinical history:

- **Date of Injury/Surgery:** [Date]
- **Site of Nonunion:** [Specific Bone Name]
- **Failed Conservative Treatment:** The patient has undergone [Number] months of immobilization with no clinical or radiographic evidence of healing.
- **Radiographic Evidence:** Serial X-rays/CT scans dated [Dates] confirm a lack of progressive healing over a [Number]-week period.
- **Complicating Factors:** [List any factors such as smoking, diabetes, or obesity if applicable].

In my professional medical opinion, the use of a bone growth stimulator is necessary to avoid further surgical intervention and to promote osteogenesis in this non-healing fracture.

Attached please find the clinic notes, operative reports, and imaging reports supporting this request.

Sincerely,

[Physician Signature]
[Physician Printed Name]