Date: [Insert Date]

To: [Insurance Company Name]
Department: Prior Authorization Department
Fax/Address: [Insert Fax Number or Address]

RE: Initial Prior Authorization Request for Portable Ultrasonic Nebulizer

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insert ID Number]
Group Number: [Insert Group Number]
Case Reference Number: [If applicable]

Dear Prior Authorization Department,

I am writing to formally request a prior authorization for a **Portable Ultrasonic Nebulizer (HCPCS Code: E0574)** for the above-mentioned patient.

Clinical Justification:
The patient has been diagnosed with [Insert Primary Diagnosis, e.g., Cystic Fibrosis, COPD, Severe Persistent Asthma] (ICD-10 Code: [Insert Code]). Due to the patient's medical condition and lifestyle requirements, a standard plug-in compressor nebulizer is insufficient for the following reasons:

- The patient requires frequent medication administration (X times per day) to maintain airway patency.
- The patient requires treatments during [work/school/travel] where a power outlet is not consistently available.
- The portability of an ultrasonic nebulizer is medically necessary to ensure strict adherence to the treatment plan and to prevent emergency room visits or hospitalizations.
- [Optional: The patient has tried and failed with standard jet nebulizers due to [Reason].]

Equipment Requested:
Device: [Brand Name/Model of Portable Ultrasonic Nebulizer]
HCPCS Code: E0574

Attached you will find the formal prescription, clinical progress notes, and the patient's current medication list. Please process this request as soon as possible to ensure the patient maintains their respiratory health.

Should you require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Name]
[NPI Number]
[Practice Name]
[Phone Number]