Date: [Insert Date]

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

RE: Initial Prior Authorization Request
Patient Name: [Insert Patient Name]
Date of Birth: [Insert Date of Birth]
Member ID: [Insert ID Number]
Group Number: [Insert Group Number]

To Whom It May Concern,

I am writing to request prior authorization for a **Hydraulic Patient Body Lift (HCPCS Code: E0630)** for the above-referenced patient. This durable medical equipment is medically necessary for the patient's safety and daily care.

Clinical Diagnosis:

- Primary Diagnosis: [Insert Diagnosis Name and ICD-10 Code]
- Secondary Diagnosis: [Insert Secondary Diagnosis, e.g., Muscle Weakness/Paralysis]

Medical Necessity Documentation:

The patient currently presents with [Insert specific functional limitations, e.g., inability to weight-bear, complete paralysis, or severe neurological deficit]. Due to these conditions, the patient is non-ambulatory and cannot perform independent transfers between a bed, wheelchair, or commode.

The requested hydraulic lift is required because:

- The patient requires the assistance of [Number] caregivers for transfers.
- Manual lifting poses a significant safety risk for falls or injury to both the patient and caregivers.
- Less intensive assistive devices (e.g., gait belts or transfer boards) have been ruled out as insufficient and unsafe due to [Insert Reason].

Prescribed Equipment:

- **Item:** Hydraulic Patient Lift (Manual/Hydraulic Pump)
- **HCPCS Code:** E0630
- **Additional Accessories:** [Insert Sling Type and Code, e.g., E0621]

Enclosed please find the formal physician's prescription and relevant clinical notes supporting this request. If you require additional information, please contact my office at [Insert Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Practice Name]
[Phone Number]