Date: [Date]

TO: [Health Plan Name / Medical Director]
ATTENTION: Utilization Management Department
FAX: [Fax Number]

RE: Diagnostic Imaging Peer-to-Peer Review Summary & Authorization Request
Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID]
Reference/Case Number: [Reference Number]

Requested Procedure: [e.g., MRI Lumbar Spine without Contrast (72148)]

Clinical Justification:

On [Date], a Peer-to-Peer review was conducted between [Ordering Physician Name] and [Medical Director Name] regarding the aforementioned request. The following clinical points were discussed to satisfy medical necessity criteria:

- **Primary Diagnosis:** [ICD-10 Code and Description]
- **Symptoms/Findings:** [Briefly describe duration and severity of symptoms]
- **Conservative Treatment:** [List physical therapy, medications, or injections and dates completed]
- **Provider Rationale:** [Briefly state why the requested imaging is necessary for the next step in treatment/surgical planning]

Peer-to-Peer Outcome Summary:

[Select One: The Medical Director indicated a verbal approval / The Medical Director requested additional documentation / The request remains denied pending further review].

Request for Authorization:

Based on the clinical discussion, we formally request the authorization for [Procedure Code]. Please provide the authorization number or a written determination to our office as soon as possible.

Thank you,

[Ordering Provider Signature]
[Ordering Provider Name/NPI]
[Facility Name]
[Phone Number]