Date: [Date]

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

RE: Request for Extension of Physical Therapy Services

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Reference/Auth Number: [Original Authorization Number]
Provider Name: [Provider/Facility Name]
NPI Number: [Provider NPI Number]

To Whom It May Concern,

This letter is a formal request to amend the existing prior authorization for the patient listed above to include additional physical therapy sessions. The current authorization is set to expire on [Current Expiration Date] or upon completion of [Current Number of Approved Visits] visits.

Requested Extension:

- **Additional Number of Visits:** [Number of requested visits]
- **Requested End Date:** [New requested expiration date]
- **Frequency:** [e.g., 2 times per week]
- **CPT Codes:** [e.g., 97110, 97112, 97140]

Clinical Justification:
The patient is currently being treated for [Diagnosis/ICD-10 Code]. While the patient has shown progress in [mention specific improvement, e.g., range of motion], they have not yet reached their functional goals regarding [mention remaining deficit, e.g., weight-bearing stability or pain-free gait]. Continued skilled therapy is medically necessary to [state goal, e.g., prevent regression or avoid surgical intervention].

Attached please find the updated Plan of Care and the most recent Progress Note documenting the patient's objective improvements and the clinical necessity for continued treatment.

Thank you for your prompt attention to this request. If you require further information, please contact our office at [Phone Number].

Sincerely,

[Provider Signature]
[Provider Name and Title]
[Clinic/Facility Name]