

[Date]

[Insurance Company Name]
[Prior Authorization Department]
[Insurance Address]
[City, State, Zip Code]

RE: Prior Authorization Amendment Request

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

To Whom It May Concern,

I am writing to request an amendment to the existing prior authorization for wound care services for the above-mentioned patient. We are requesting an increase in the frequency of wound care visits from [Current Frequency, e.g., 1 time per week] to [Requested Frequency, e.g., 3 times per week].

Clinical Justification:

Since the initial authorization, the patient's clinical status has changed. The wound located at [Wound Location] has shown [describe change: e.g., increased drainage, signs of infection, or stagnant healing]. To prevent further complications, hospital readmission, or surgical intervention, increased clinical monitoring and more frequent debridement/dressing changes are medically necessary.

Requested Change:

- Current Authorization: [Number] visits per week.
- Amended Request: [Number] visits per week.
- Effective Date of Increase: [Date].
- Duration: [Number of weeks/months].

Attached are the updated clinical notes and wound measurements supporting this request. Please process this amendment as soon as possible to ensure continuity of care.

Should you require additional information, please contact our office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, Title]

[NPI Number]
[Facility Name]