

Date: [Date]

To: [Name of Insurance Company]

Attn: Prior Authorization/Utilization Management Department

Fax/Address: [Fax Number or Mailing Address]

RE: Amendment to Existing Prior Authorization

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

Member ID: [Insurance Member ID]

Original Reference/Auth Number: [Original Authorization Number]

Provider Name: [Requesting Physician Name]

To Whom It May Concern,

I am writing to formally request an amendment to the existing prior authorization referenced above. We are requesting the inclusion of advanced diagnostic imaging to the currently approved plan of care.

Requested Procedure(s):

- [CPT Code] - [Description of Imaging, e.g., MRI Brain with Contrast]
- [CPT Code] - [Description of Imaging]

Clinical Justification:

The addition of this diagnostic imaging is medically necessary for the following reasons:
[Insert brief clinical explanation, e.g., change in patient symptoms, need for surgical planning, or failure of conservative treatment].

Relevant Diagnosis Codes:

[ICD-10 Code] - [Diagnosis Description]

Attached please find supporting clinical documentation, including recent office notes and previous test results, that justify the necessity of this advanced imaging.

Please process this amendment at your earliest convenience to avoid delays in patient care. If you require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, Title]

[Practice/Facility Name]

[NPI Number]