

Date: [Date]

TO: [Insurance Provider Name]

ATTN: Prior Authorization/Medical Review Department

Fax/Address: [Fax Number or Mailing Address]

RE: Prior Authorization Amendment / Extension Request

Patient Name: [Patient First and Last Name]

Date of Birth: [Patient DOB]

Member ID: [Member ID Number]

Original Authorization #: [Original Auth Number]

Provider Tax ID/NPI: [Provider NPI]

To Whom It May Concern,

I am writing to request an amendment to the current prior authorization for Cardiac Rehabilitation for the above-referenced patient. We are requesting an extension of [**Number of Additional Sessions**] sessions over an additional [**Number of Weeks/Months**].

Clinical Justification for Extension:

- **Current Diagnosis:** [e.g., Status post-MI, CABG, Chronic Heart Failure]
- **Progress to Date:** [Briefly describe functional improvements, e.g., increased MET levels or improved 6-minute walk test].
- **Reason for Extension:** [Select one: Patient missed sessions due to illness/hospitalization / Patient requires more time to reach functional goals / Co-morbidities have slowed progress].
- **Medical Necessity:** Continued supervised exercise is required to ensure cardiovascular stability and prevent hospital readmission.

Requested Extension Details:

Requested End Date: [New End Date]

Total Sessions Requested: [Total Number]

Attached please find the patient's most recent progress notes and initial evaluation for your review. If you require further information, please contact our office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Facility Name]