

Date: [Date]

To: [Health Insurance Company Name]

Attn: Prior Authorization Department

Fax/Address: [Fax Number or Mailing Address]

RE: Amendment to Prior Authorization Request

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Member ID: [Member ID Number]

Original Authorization Reference #: [Original Auth Number]

To Whom It May Concern,

I am writing to request an amendment to the previously approved prior authorization for the Durable Medical Equipment (DME) referenced above. Due to [Reason for Substitution: e.g., product unavailability, change in clinical status, or updated provider recommendation], a substitution of the equipment is necessary.

Original Requested Equipment:

Item Name: [Original Item Name]

HCPCS Code: [Original Code]

Substituted Equipment Requested:

Item Name: [New Item Name]

Model/Manufacturer: [New Model Info]

HCPCS Code: [New Code]

The substituted equipment meets the same medical necessity criteria as originally documented. This change is required to ensure the patient receives the appropriate therapy without delay. All other clinical documentation provided in the initial request remains valid.

Please update the existing authorization to reflect this substitution. If you require additional clinical information, please contact my office at [Phone Number].

Sincerely,

[Provider Name/Signature]

[Provider NPI Number]

[Facility/Clinic Name]