Date: [Date]

To: [Insurance Company Name]
Attention: Utilization Management/Prior Authorization Department
Fax Number: [Fax Number]

RE: Prior Authorization Request for Epidural Steroid Injection (ESI)

Patient Information:
Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [ID Number]
Group Number: [Group Number]

Provider Information:
Requesting Provider: [Physician Name]
NPI Number: [NPI Number]
Clinic Name: [Clinic Name]
Phone/Fax: [Phone and Fax Numbers]

Clinical Information:
Diagnosis Code(s): [ICD-10 Codes, e.g., M54.16 - Lumbar Radiculopathy]
Procedure Code(s): [CPT Codes, e.g., 62323 or 64483]
Requested Date of Service: [Date]
Level of Injection: [e.g., L4-L5, L5-S1]
Type of Injection: [Interlaminar, Transforaminal, or Caudal]

Medical Necessity Summary:
The patient presents with chronic pain radiating to the [Location, e.g., lower extremities] lasting for [Duration] months/years. Physical examination findings include [Brief findings, e.g., positive straight leg raise, weakness, or sensory loss].

Previous Conservative Treatments Attempted:

- Physical Therapy: [Dates/Duration] - [Outcome]
- Medications (NSAIDs, muscle relaxants, gabapentinoids): [List meds] - [Outcome]
- Home Exercise Program/Activity Modification: [Details]

Imaging Results:
[Date of MRI/CT]: Results show [Summary of findings, e.g., herniated disc or spinal stenosis] correlating with the patient's clinical symptoms.

Please review the attached clinical notes and imaging reports. We request an expedited review to manage the patient's pain and avoid more invasive surgical interventions.

Sincerely,

[Physician Signature]
[Physician Printed Name]