Date: [Date]
To: [Insurance Company Name]
Attention: Medical Review/Appeals Department
Fax/Address: [Fax Number or Address]

RE: Letter of Medical Necessity for Facet Joint Injections
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Policy Number: [Policy #]
Group Number: [Group #]
Claim/Reference Number: [Claim #, if applicable]

To Whom It May Concern,

I am writing to formally request authorization for [Diagnostic/Therapeutic] Facet Joint Injections for the above-referenced patient. This procedure is medically necessary to manage chronic pain originating from the [Cervical/Thoracic/Lumbar] spine at levels [List Levels, e.g., L4-L5, L5-S1].

Patient Diagnosis:
[ICD-10 Code] - [Diagnosis Name, e.g., Spondylosis with Radiculopathy]
[ICD-10 Code] - [Diagnosis Name, e.g., Facet Joint Syndrome]

Clinical Documentation:
The patient has been suffering from chronic facet-mediated pain for [Duration] months/years. Physical examination reveals tenderness over the facet joints, pain with spinal extension, and localized stiffness. Diagnostic imaging [MRI/CT/X-ray] dated [Date] confirms [Specific Findings, e.g., facet hypertrophy or degenerative changes].

Failed Conservative Treatments:
Prior to this recommendation, the patient has completed the following without adequate relief:

- Physical Therapy: [Duration] weeks, from [Start Date] to [End Date].
- Medication Management: [NSAIDs, Muscle Relaxants, etc.] for [Duration].
- Home Exercise Program: Consistently performed for [Duration].
- Activity Modification: Implemented for [Duration].

Medical Justification:
The patient continues to experience significant functional impairment, limiting activities of daily living (ADLs) and work capacity. Facet joint injections are required to [select one: confirm the pain source / provide therapeutic relief] and to facilitate the patient's progress in a rehabilitative program.

I request that you approve this procedure to prevent further decline in the patient's condition. Please contact my office at [Phone Number] if you require additional medical records or clinical notes.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Practice Name]
[NPI Number]
[Phone Number]