[Date]
[Insurance Company Name]
[Prior Authorization Department]
[Address]
[City, State, Zip Code]

RE: Clinical Justification for Intra-Articular Joint Injection
Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Policy ID Number]
Group Number: [Group Number]
Case Reference Number: [Case # if applicable]

To Whom It May Concern,

I am writing to provide clinical justification for the medical necessity of an intra-articular joint injection for the above-referenced patient. I have diagnosed the patient with [Specific Diagnosis/ICD-10 Code] affecting the [Right/Left/Bilateral] [Specific Joint, e.g., Knee, Shoulder].

Clinical History and Exam Findings:
The patient presents with persistent symptoms of [Pain, Swelling, Reduced Range of Motion] lasting for [Duration]. Physical examination reveals [List Findings, e.g., Crepitus, Joint Line Tenderness, Limited Flexion]. Imaging studies performed on [Date] show [Summary of X-ray/MRI findings].

Conservative Treatments Attempted:
The patient has failed to respond adequately to conservative management, including:

- Physical Therapy: [Number of weeks/months completed]
- Oral Medications: [NSAIDs/Analgesics names and dosages]
- Activity Modification: [Details of modifications]
- Previous Injections: [Details if applicable]

Despite these interventions, the patient continues to experience significant functional impairment and pain that interferes with activities of daily living.

Proposed Treatment Plan:
I am requesting approval for the administration of [Specific Substance, e.g., Corticosteroid, Hyaluronic Acid] via intra-articular injection. This procedure is indicated to reduce inflammation, alleviate pain, and postpone more invasive surgical interventions such as [Arthroplasty/Joint Replacement].

In my professional medical opinion, this treatment is medically necessary and is the most appropriate next step in the patient's care. Please contact my office at [Phone Number] if further documentation is required.

Sincerely,

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