[Physician Name]
[Practice Name]
[Street Address]
[City, State, Zip Code]
[Phone Number]
[Fax Number]

[Date]

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

RE: Follow-Up on Prior Authorization Request

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Reference/Case Number: [Reference Number if applicable]
Requested Procedure: [Specific Type of Injection, e.g., Epidural Steroid Injection]

To Whom It May Concern,

I am writing to follow up on the prior authorization request submitted on [Date of Original Submission] for the above-referenced patient regarding continued pain management injections.

The patient has been diagnosed with [Diagnosis/ICD-10 Code]. To date, the patient has completed [Number] previous injections, which resulted in a [Percentage]% reduction in pain and a significant improvement in functional mobility for a period of [Duration]. Without the continuation of this treatment, the patient experiences a return of debilitating pain that limits activities of daily living and increases reliance on oral medications.

Attached to this letter, please find updated clinical notes, recent imaging reports, and the previous procedure results documenting the medical necessity for continued treatment. This requested procedure is essential to maintain the patient's current level of function and prevent clinical regression.

We request an expedited review of this case to avoid any disruption in the patient's care plan. Please notify our office of your decision via fax at [Fax Number] or phone at [Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Physician Signature]
[Physician Name, Title]
[NPI Number]