Date: [Date]
To: [Insurance Company Name]
Attn: Prior Authorization Department
Fax/Phone: [Insurance Fax/Phone Number]

RE: PRIOR AUTHORIZATION REQUEST FOR SACROILIAC JOINT INJECTION

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Group Number: [Group Number]
Case/Reference Number: [Case Number, if applicable]

Dear Medical Review Department,

I am writing to request prior authorization for a **Sacroiliac (SI) Joint Injection** for the above-referenced patient. This procedure is medically necessary to treat chronic low back/buttock pain localized to the sacroiliac joint.

Clinical Justification:

- **Diagnosis:** [e.g., Sacroiliitis / SI Joint Dysfunction]
- **ICD-10 Code:** [e.g., M53.3]
- **CPT Code:** [e.g., 27096]
- **Pain Duration:** [Number of months/years]
- **Physical Exam Findings:** [e.g., Positive Patrick's (FABER) test, Gaenslen's test, or tenderness over the SI joint]

Conservative Treatments Attempted:

- **Physical Therapy:** [Dates/Duration]
- **Medications:** [e.g., NSAIDs, Muscle Relaxants - List names and duration]
- **Home Exercise/Activity Modification:** [Details]

The patient continues to experience significant functional impairment and pain despite these conservative measures. The requested injection is intended for both diagnostic confirmation and therapeutic relief.

Attached please find the patient's clinical notes, physical exam results, and imaging reports (X-ray/MRI) supporting this request.

Thank you for your prompt attention to this matter. If you require further information, please contact my office at [Provider Phone Number].

Sincerely,

[Physician Signature]
Provider Name: [Physician Name, MD/DO]
NPI Number: [NPI Number]
Facility Name: [Clinic/Hospital Name]