[Physician Name]
[Clinic/Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

To: [Insurance Company Name / Medical Review Department]
Attn: [Contact Person or Department]
Fax: [Fax Number]

RE: Letter of Medical Necessity for Nerve Block Injection

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

To Whom It May Concern,

I am writing to provide supporting documentation for the medical necessity of [Type of Nerve Block, e.g., Occipital, Genicular, Medial Branch Block] for the above-named patient. The patient has been diagnosed with [ICD-10 Code and Diagnosis Name].

Clinical History:
The patient has been suffering from chronic pain for [Duration]. The pain is described as [Description: sharp, radiating, burning] and is located in the [Specific Anatomical Region]. This condition has significantly impacted the patient's daily activities, including [List limitations, e.g., walking, sleeping, working].

Prior Treatments Exhausted:
The patient has attempted the following conservative treatments without adequate or sustained relief:

- Physical Therapy: [Dates/Duration]
- Oral Medications: [List: NSAIDs, Muscle Relaxants, Gabapentinoids, etc.]
- Activity Modification: [Details]
- Other Interventions: [List previous injections or therapies]

Rationale for Procedure:
The proposed nerve block injection (CPT Code: [CPT Code]) is necessary to [select: provide diagnostic clarity / achieve therapeutic pain reduction]. By targeting the [Specific Nerve], we aim to reduce inflammation, interrupt the pain cycle, and improve the patient's functional status. This procedure may also help determine the necessity of more permanent interventions, such as radiofrequency ablation.

Based on the patient's clinical presentation and failure to respond to conservative management, this procedure is the most appropriate next step in their care plan. I request your prompt approval of this authorization request.

Please contact my office at [Phone Number] if you require additional medical records or have further questions.

Sincerely,

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