**Date:** [Date]

**TO:** [Insurance Company Name]
**ATTN:** Medical Review Department / Utilization Management

**RE: Request for Peer-to-Peer Discussion**

**Patient Name:** [Patient Name]
**Date of Birth:** [Patient DOB]
**Policy/Member ID:** [Member ID]
**Reference/Authorization Number:** [Reference Number]
**Requested Procedure:** [Type of Injection, e.g., Lumbar Epidural Steroid Injection]
**CPT Code(s):** [CPT Codes]

To Whom It May Concern,

I am writing to formally request a Peer-to-Peer clinical review regarding the recent denial of the pain management procedure mentioned above. I believe this treatment is medically necessary for the management of the patient's chronic pain and functional limitations.

The patient has failed conservative treatments, including [List treatments, e.g., physical therapy, NSAIDs, home exercise]. Physical examination and imaging studies [e.g., MRI/CT] confirm the diagnosis of [Diagnosis/ICD-10 Code], which correlates with the patient's clinical symptoms.

I would like to discuss the clinical indicators and the patient's specific history with a medical director of the same or similar specialty (Pain Management or Anesthesiology/Physiatry).

**Provider Availability for Call:**

- [Option 1: Date and Time Range]
- [Option 2: Date and Time Range]

Please contact our office at **[Phone Number]** or via email at **[Email Address]** to confirm a time or to provide a direct line for the reviewing physician.

Thank you for your prompt attention to this matter.

Sincerely,

[Doctor Name, MD/DO]
[Practice Name]
[Tax ID/NPI]