Date: [Date]

TO: [Insurance Company Name]
ATTN: Prior Authorization/Medical Review Department
FAX: [Fax Number]
PHONE: [Phone Number]

RE: Prior Authorization Renewal Request for Chronic Pain Management
Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Group Number: [Group Number]
Request Reference Number (if previous): [Previous Auth Number]

Dear Medical Review Department,

This letter is to request a prior authorization renewal for continued pain management injections for the above-referenced patient. The patient has been diagnosed with [Diagnosis/ICD-10 Code] and has been receiving [Type of Injection, e.g., Epidural Steroid Injections/Facet Joint Blocks].

Clinical Justification for Renewal:

- **Previous Response:** Following the last series of injections administered on [Dates], the patient reported a [Percentage]% reduction in pain levels and a significant improvement in functional mobility.
- **Duration of Relief:** The therapeutic benefit lasted for [Number] months, allowing the patient to [e.g., participate in physical therapy / reduce opioid consumption].
- **Current Status:** The patient is experiencing a return of symptoms that significantly impair daily activities. Continued treatment is medically necessary to maintain functional status and avoid more invasive surgical interventions.

Requested Service:

Procedure Code(s): [CPT Codes]
Frequency/Quantity: [Number of injections requested over specific time period]
Facility Name: [Facility Name and NPI]

Attached please find updated clinical notes, imaging reports (MRI/CT), and the patient's pain diary supporting this renewal. If you require additional information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]

[NPI Number]
[Practice Name]