DATE: [Date]

TO: [Insurance Company Name]
ATTN: Prior Authorization Department
FAX/ADDRESS: [Fax Number or Address]

RE: Prior Authorization Request for Initial Clinical Evaluation

PATIENT INFORMATION:
Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [ID Number]
Group Number: [Group Number]

PROVIDER INFORMATION:
Provider Name: [Provider Name]
NPI Number: [NPI Number]
Tax ID: [Tax ID]
Phone Number: [Phone Number]

REQUEST DETAILS:

Procedure Code (CPT): [e.g., 99203, 99204, 90791]
Diagnosis Code (ICD-10): [Diagnosis Code]
Proposed Date of Service: [Date]

CLINICAL JUSTIFICATION:

The patient is being referred for an initial clinical evaluation due to: [Briefly describe symptoms or medical necessity]. This evaluation is necessary to establish a diagnosis, determine the severity of the condition, and develop an appropriate treatment plan.

[Optional: Mention any failed conservative treatments or previous screenings here].

Please review this request for medical necessity. If you require additional clinical documentation, please contact our office at [Phone Number].

Sincerely,

[Provider Signature]
[Provider Printed Name]
[Facility Name]