Date: [Date]

To: [Insurance Company Name]
Attention: [Prior Authorization/Appeals Department]
Fax/Address: [Fax Number or Mailing Address]

RE: Letter of Medical Necessity for Advanced Diagnostic Imaging

Patient Name: [Patient First and Last Name]
Date of Birth: [Patient DOB]
Policy ID Number: [Insurance ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number if applicable]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to request coverage for the following advanced diagnostic procedure: **[Specific Procedure Name, e.g., MRI Brain with and without contrast] (CPT Code: [CPT Code])**.

Clinical Background:
The patient presents with [Primary Diagnosis/Symptoms]. These symptoms have persisted for [Duration]. The clinical objective for this imaging is to [Reason for scan, e.g., rule out malignancy, evaluate structural damage, or guide surgical planning].

Medical History and Failed Conservative Treatments:
[Patient Name] has undergone the following treatments and/or preliminary diagnostics without resolution or sufficient clarity:

- [Previous Imaging, e.g., X-ray or Ultrasound results and dates]
- [Trial of Medications, e.g., NSAIDs, Steroids]
- [Physical Therapy/Conservative Management duration]
- [Relevant Laboratory Findings]

Clinical Justification:
The requested [Procedure Name] is medically necessary because [Specific reason why this scan is the gold standard for this diagnosis]. At this stage, the information provided by this advanced imaging is critical to determining the next steps in the patient's treatment plan and preventing [Potential complications or worsening of condition].

I request that you approve this request for [Procedure Name]. If you require additional clinical documentation or have questions, please contact my office at [Phone Number].

Sincerely,

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