Prior Authorization Request for Diagnostic Imaging

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert Patient DOB]

Insurance Provider: [Insert Insurance Provider]

Policy Number: [Insert Policy Number]

Physician Name: [Insert Physician Name]

Physician Contact Information: [Insert Contact Information]

Request Details

We are requesting prior authorization for the following diagnostic imaging procedure:

- **Procedure:** [Insert Imaging Procedure, e.g., MRI, CT Scan]
- **Location:** [Insert Facility Name]
- **Requested Date:** [Insert Requested Date]

Clinical Information

The medical necessity for this procedure is based on the following:

[Insert clinical rationale, including symptoms, history, and any relevant findings.]

Supporting Documentation

Enclosed are the following documents to support this request:

- Clinical notes
- Previous imaging results (if applicable)
- Referral documentation (if applicable)

Conclusion

We appreciate your prompt attention to this request and look forward to your approval.

Sincerely,

[Insert Physician Signature]

[Insert Physician Printed Name]

[Insert Physician NPI Number]