

Sample Pre-Authorization Request

Pre-Authorization Department

Insurance company name:

Address

Address

Re: Patient Name
Member ID:

Insured:
Group #

Request for pre-authorization for ExAblate MR guided Focused Ultrasound Surgery (MRgFUS) treatment for uterine fibroids

This patient has come to our center to undergo ExAblate 2000 MRgFUS for the treatment of her uterine fibroids.

Description of Diagnosis: _____

Symptoms:

- | | |
|--|---|
| <input type="checkbox"/> DUB, Menorrhagia,
Menometrorrhagia | <input type="checkbox"/> Pelvic Pressure |
| <input type="checkbox"/> Abdominal Bloating | <input type="checkbox"/> Dyspareunia |
| <input type="checkbox"/> Dysmenorrhea | <input type="checkbox"/> Secondary Urinary Symptoms |
| <input type="checkbox"/> Secondary GI symptoms | <input type="checkbox"/> Anemia |

Studies done: Pap _____; Ultrasound of Pelvis found _____;
MR of Pelvis found:

History:

Medical Necessity: The patient should undergo MR guided Focused Ultrasound vs. other treatment alternatives because

Treatment plan (tx preparation, day of tx, post-tx care, recovery and return to work)

About ExAblate

Enclosed please find the following information about ExAblate and MRgFUS: FDA Talk paper, FDA approval, AJR article, Fertility and Sterility article, and patient pamphlet.

Should you require any additional information regarding Ms. _____ medical condition please contact her directly. If you require information about the procedure of charges please feel free to contact me at XXXXXXXXXX. Thank you for your consideration.

Sincerely,