[Date]
[Health Plan Name]
[Street Address]
[City State Zip]

RE: [Patient's Name/Policy Number]
Coverage of the ProDisc-C™ artificial cervical disc

Dear Dr. [Type Doctor's Name] :

I am writing to justify coverage for cervical disc arthroplasty using the ProDisc-C™ artificial disc.

[Patient's Name] suffers from [insert patient diagnosis]. A copy of her most recent medical record is enclosed for your review. I strongly believe that this patient's condition and medical history make her an appropriate candidate for cervical disc arthroplasty. This procedure is medically necessary and warrants coverage given Ms. [patient's last name] medical history.

History:
[note patient's previous treatments, how long the patient has had symptoms and how these symptoms have affected his/her quality of life.]

I will be submitting CPT Codes 22856, total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression) cervical; single interspace.

Enclosed you will find clinical and technical information outlining the safety and efficacy of cervical disc arthroplasty using the ProDisc-C artificial disc. I believe this information paired with the patient's medical record substantiate coverage and payment for the procedure. I request confirmation that cervical disc arthroplasty is a covered benefit based on medical necessity, and that associated professional fees for treatment will be covered.

If you require additional information, please contact me at [Insert Telephone Number].
Thank you for your timely response.

Sincerely,

[Physician Name]
TIN

Enclosures:
- FDA Approval Letter
- Summary of Safety and Effectiveness
- Patient Medical History