**[Physician Letterhead]**

Attn: [Medical Director] RE: [Patient Name]

 [Insurance company] [Date of Birth]

 [Address] [Policy Number]

 [City, State, ZIP code] [Claim Number]

Request: Authorization for treatment with i-FACTOR®

Diagnosis: [Diagnosis and ICD-10 code]

To whom it may concern,

On behalf of [Patient Name], I am writing to document the medical necessity of i-FACTOR®, which is indicated for the use for anterior cervical discectomy and fusion (ACDF). This request is supported by the following information:

**Summary of Patient’s History**

* [Patient’s diagnosis, date of diagnosis]
* [Laboratory and imaging results and dates]
* [Brief description of patient’s current medical condition]
* [Patient’s previous and current treatments]
* [Patient’s response to those treatments]

**Rationale for Treatment**

Considering the patient’s medical history, current medical condition, and the supporting use of i-FACTOR®, I believe treatment with i-FACTOR® at this time is warranted, appropriate, and medically necessary for this patient.

The following documentation is enclosed:

* i-FACTOR® Instructions for Use and FDA Approval Letter
* [Medical literature regarding the use of i-FACTOR® for Diagnosis name; ICD-10 Code]
* [Relevant clinical documentation such as history and physical, progress notes, treatment history, and outcomes]

If you have any further questions regarding this matter or need additional information, please contact my office at [Phone Number]. I look forward to your timely response.

Sincerely,

[Insert physician name and participating provider number]

Enclosures

**Important Information:**

The information contained in this template letter is provided by Cerapedics for informational purposes for patients who have been treated with i-FACTOR® and does not constitute reimbursement or legal advice. Clinical information provided to any federal, state or commercial payor must be supported by documentation in the patient’s medical record.

Cerapedics does not promise or guarantee coverage, payment, or rate of payment for i-FACTOR in anterior cervical discectomy and fusion (ACDF) or any other services or line items billed in conjunction with the use of i-FACTOR in ACDF. The provider accepts full risk for reimbursement pertaining to the foregoing for each patient.  It is always the responsibility of the provider to accurately document patient clinical condition and to appropriately select and report patient diagnosis as well as services delivered. The provider is responsible for the accuracy of all communications with payors including, but not limited to, the information submitted in relation to this document. The provider is responsible for determining medical necessity and the proper site for use of i-FACTOR in ACDF, and for submitting appropriate codes, charges, and modifiers for services rendered.

There is no requirement that any patient or healthcare provider uses i-FACTOR in exchange for this information. Use of the information in this letter does not guarantee that the health plan will provide reimbursement for -FACTOR in ACDF and this information not intended to be a substitute for, or an influence on, the independent medical judgment of the physician.  All reimbursement and health economic information provided by Cerapedics is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules, and policies.

For additional questions or assistance on approval of i-FACTOR, please contact **reimbursement@cerapedics.com** ML-0771 01.17.2023 ©2023 Cerapedics Inc.