INSURANCE COMPANY LETTER OF MEDICAL NECESSITY

Patient Information:

Full Name: ______________________________

Date of Birth: ______________________________

Policy Number: ______________________________

Insurance Company: ______________________________

Provider Information:

Provider Name: ______________________________

NPI Number: ______________________________

Address: ______________________________

Phone Number: ______________________________

Equipment/Service Information:

Equipment/Service Name: ______________________________

HCPCS/CPT Code(s): ______________________________

Quantity: ______________ Duration of Need: ______________________________

Clinical Justification:

The equipment/service described above is medically necessary for the treatment of the patient due to the following clinical reasons. The patient’s diagnosis, functional limitations, and clinical findings support the need for this equipment/service. The expected benefit includes improvement in functional capacity, prevention of further injury, or maintenance of current health status. Alternative treatments have been considered and deemed insufficient or inappropriate. The patient’s condition requires the use of this equipment/service as part of a comprehensive treatment plan.

Diagnosis and Medical Codes:

Primary Diagnosis (ICD-10): ______________________________

Secondary Diagnosis (ICD-10): ______________________________

Treatment and Care Plan:

The patient is currently under the care of the undersigned provider, and the prescribed equipment/service is an integral part of the ongoing treatment plan. The equipment/service is expected to optimize the patient's health outcomes and support rehabilitation efforts. The provider will monitor the patient’s progress and adjust the treatment plan as necessary to ensure the continued medical necessity of the equipment/service.

Statement of Medical Necessity:

I certify that the equipment/service requested is medically necessary and reasonable for the diagnosis and condition of the patient described herein. This determination is based on my professional medical judgment and the patient’s clinical

needs as documented in the medical record. The requested equipment/service complies with all pertinent regulations and guidelines governing medical necessity under United States law.

Additional Information:

Please contact the undersigned provider for any additional information, clarifications, or supporting documentation needed to facilitate prompt and accurate processing of this request.

PROVIDER SIGNATURE	**PROVIDER NAME**
Signature: ___________________________	Print Name: ___________________________

Provider Contact Information:

Phone: ______________________________ Fax: ______________________________

Email: ____

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