LETTER OF MEDICAL NECESSITY

Patient Name: ______________________________ Date of Birth: ______________

Address: ____

Phone Number: ____

Physician Information:

Physician Name: ____

Physician NPI Number: ____

Practice Name: ____

Practice Address: ____

Phone Number: ____

Medical Necessity Statement:

This letter is to certify that the above-named patient has a medically necessary need for the prescribed equipment and/or services as outlined herein. The patient's diagnosis and clinical condition require this equipment and/or services to improve, maintain, or restore functional capabilities or to prevent significant deterioration.

Patient Diagnosis and Clinical Findings:

Primary diagnosis (ICD-10 code): ____ Secondary diagnosis (if applicable): ____ Clinical findings and symptoms demonstrating medical necessity:

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Prescribed Equipment and/or Services:

Description of equipment and/or services: _____________________________________ Quantity (if applicable): ______________________ HCPCS/Procedure codes (if known): ____ Expected duration of need: ____ Additional comments or instructions:

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Supporting Clinical Information:

Relevant medical history, prior treatments, and clinical rationale supporting the need for the prescribed equipment and/or services:

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Physician's Attestation and Signature:

I certify that the information provided in this letter is true, accurate, and complete to the best of my knowledge. The prescribed equipment and/or services are medically necessary for the patient named herein and consistent with the standards of medical practice.

Physician Signature: ____

Date: ______________________

Physician Name (Printed)	**Physician NPI Number**

Signature: ___________________________ Date: ___________________________

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