

[Date]

[Insurance Company Name]
[Claims/Appeals Department]
[Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for [Patient Name]

Date of Birth: [Patient DOB]

Policy Number: [Policy ID Number]

Group Number: [Group Number]

Case Reference Number: [Reference Number, if applicable]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to formally request coverage for [Specific Service/Therapy/Equipment]. [Patient Name] is currently under my care for the treatment of Developmental Delay.

Clinical Diagnosis:

[Patient Name] has been diagnosed with [Specific Diagnosis Code, e.g., ICD-10 F82 or R62.50]. Clinical evaluations indicate significant delays in the following areas: [List areas, e.g., Speech and Language, Gross/Fine Motor Skills, Cognitive Development, Social-Emotional Skills].

Current Clinical Status:

[Patient Name] currently presents with [Briefly describe specific functional limitations or symptoms]. Based on standardized testing performed on [Date], the patient is functioning at a level equivalent to [Age] months/years, representing a [Percentage]% delay compared to chronological age.

Treatment Plan and Recommendation:

To address these deficits and prevent further developmental regression, I am prescribing the following medically necessary intervention: [Specify Service, e.g., Occupational Therapy 2x weekly].

Clinical Justification:

This treatment is essential to [Patient Name]'s health and development. The goal of this intervention is to [State goal, e.g., achieve age-appropriate communication, improve physical mobility, or increase independence in activities of daily living]. Without these services, the patient is at high risk for [List risks, e.g., permanent functional loss, secondary complications, or inability to integrate into an educational setting].

In my professional opinion, the requested services are medically necessary, evidence-based, and appropriate for the patient's condition. Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]

[Address]