

[Doctor Name, Credentials]
[Clinic/Hospital Name]
[Department of Ophthalmology]
[Address]
[Phone Number]
[Date]

To: [Recipient Name/Insurance Provider]
Re: [Patient Name]
DOB: [Patient Date of Birth]
ID: [Patient ID/Policy Number]

Dear [Recipient Name],

I am writing to formally recommend medical treatment for [Patient Name], who is currently under my care for the management of Diabetic Macular Edema (DME) in the [Left/Right/Both] eye(s).

Clinical Diagnosis:

The patient has been diagnosed with Center-Involved Diabetic Macular Edema (ICD-10 Code: [Insert Code]). Clinical examination and Optical Coherence Tomography (OCT) imaging confirm the presence of intraretinal fluid and significant macular thickening, which currently threatens the patient's central vision.

Proposed Treatment Plan:

Based on the severity of the edema and the patient's clinical history, I recommend the following course of treatment:

- Medication/Procedure: [e.g., Eylea, Lucentis, Vabysmo, or Focal Laser]
- Frequency: [e.g., Monthly injections or as needed based on clinical response]
- Duration: [Estimated duration of initial loading phase]

Medical Necessity:

The primary goal of this treatment is to reduce retinal swelling, prevent further vision loss, and potentially improve visual acuity. Without timely intervention, DME carries a high risk of permanent vision impairment and legal blindness. Conservative management is not recommended at this stage due to the center-involved nature of the edema.

Please authorize the recommended treatment to ensure the patient receives the necessary care to preserve their sight.

Sincerely,

[Doctor Signature]

[Doctor Printed Name]
[NPI Number]