

Date: [Date]

To: [Insurance Company Name]

Attn: Appeals/Authorization Department

Address: [Insurance Company Address]

Patient Name: [Patient Full Name]

Policy Number: [Policy ID Number]

Group Number: [Group Number]

Date of Birth: [Patient DOB]

Subject: Letter of Medical Necessity for Reconstructive Plastic Surgery

Dear Medical Reviewer,

I am writing on behalf of [Patient Name] to request authorization for [Name of Procedure, e.g., Septoplasty, Breast Reconstruction, Panniculectomy]. This procedure is not cosmetic in nature; it is a reconstructive surgery required to restore function and/or correct a physical deformity resulting from [Congenital Anomaly / Trauma / Infection / Tumor / Disease / Previous Surgery].

Clinical History and Diagnosis:

The patient has been diagnosed with [Diagnosis/ICD-10 Code]. [Briefly describe the medical history leading to the need for surgery].

Functional Impairment:

The patient is currently experiencing the following functional impairments due to this condition:

- [List impairment 1, e.g., chronic pain]
- [List impairment 2, e.g., restricted range of motion]
- [List impairment 3, e.g., recurrent infections or skin breakdown]

Previous Treatments:

Conservative treatments have been attempted, including [List treatments, e.g., physical therapy, medications, specialized clothing], but have failed to alleviate the patient's symptoms.

Recommended Treatment Plan:

I have recommended [Specific Procedure and CPT Code] to improve [Specific Function] and prevent further complications. This surgery is the standard of care for this diagnosis and is medically necessary to improve the patient's health and daily functioning.

Attached please find supporting documentation, including [Medical Records / Clinical Photos / Test Results].

Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Practice Name]

[NPI Number]