Date: [Date]

To: [Insurance Company Name / Medical Review Department]
Fax/Address: [Fax Number or Address]

RE: Letter of Medical Necessity for Hormone Replacement Therapy

Patient Name: [Patient Full Name]
Date of Birth: [Date of Birth]
Policy ID: [Insurance ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to document the medical necessity of Hormone Replacement Therapy (HRT). [Patient Name] has been under my care since [Date], and I have diagnosed them with [Diagnosis Name, e.g., Gender Dysphoria / Hypogonadism / Menopause-related Vasomotor Symptoms], ICD-10 code [Insert Code].

The patient presents with the following clinical symptoms:

- [Symptom 1]
- [Symptom 2]
- [Symptom 3]

I am prescribing the following medication(s) as part of the treatment plan:

Medication: [Specific Medication and Dosage]

This treatment is medically necessary to alleviate the patient's symptoms and improve their overall health outcomes. Failure to provide this therapy may result in [mention risks, e.g., significant psychological distress, bone density loss, or worsening of clinical condition].

Based on the patient's medical history and current clinical guidelines, I request that you approve coverage for this treatment. Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Practice Name]
[NPI Number]
[Phone Number]