Date: [Insert Date]

To: [Insurance Company Name]
Attention: Medical Review/Appeals Department
Address: [Insert Address]
Policy Number: [Insert Member ID]
Group Number: [Insert Group Number]

RE: Letter of Medical Necessity for Permanent Hair Removal

Patient Name: [Insert Patient Name]
Date of Birth: [Insert Date of Birth]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to document the medical necessity of permanent hair removal (electrolysis/laser hair removal) as a critical component of their treatment plan.

Diagnosis:
The patient has been diagnosed with [Insert Diagnosis, e.g., Gender Dysphoria (ICD-10 F64.0), Polycystic Ovary Syndrome (E28.2), or Hidradenitis Suppurativa (L73.2)].

Clinical Rationale:
The requested procedure is medically necessary for the following reason(s):

- [Reason 1: e.g., Treatment for Gender Affirmation surgery preparation (site clearing)]
- [Reason 2: e.g., Prevention of recurrent skin infections or folliculitis]
- [Reason 3: e.g., Mitigation of severe psychological distress caused by the condition]

Treatment Plan:
I am prescribing [Electrolysis/Laser Hair Removal] for the following area(s): [Insert Body Areas]. This treatment is not for cosmetic purposes but is a functional requirement to [Insert Goal, e.g., prevent post-surgical complications or manage a chronic skin condition].

Provider Information:
I strongly recommend that coverage for this treatment be approved. Please contact my office at [Insert Phone Number] if you require further clinical documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Clinic Name]