Date: [Insert Current Date]

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

RE: Letter of Medical Necessity Submission

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Policy Number: [ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Insert Number if applicable]

To Whom It May Concern,

Please find the enclosed Letter of Medical Necessity regarding the [Treatment/Medication/Procedure/Equipment] prescribed for the above-mentioned patient by [Physician's Name].

This document is being submitted on **[Insert Submission Date]** to support the clinical requirement for this service and to ensure coverage under the patient's benefits plan. The attached letter details the patient's diagnosis, medical history, and the necessity of the requested intervention.

We request a formal review of this documentation. Please notify both the provider and the patient of your coverage determination within the standard processing timeframe.

Should you require additional information, please contact [Provider Name/Office Contact] at [Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Relationship to Patient]

Enclosures:
- Letter of Medical Necessity signed by [Physician Name]
- Supporting Clinical Records