[Physician Name]
[Practice/Institution Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]
[Date]

[Insurance Company Name]
[Claims/Appeals Department]
[Address Line 1]
[City, State, Zip Code]

RE: Letter of Medical Necessity for [Patient Name]

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Policy ID Number: [Policy Number]
Group Number: [Group Number]
Claim Number (if applicable): [Claim Number]

To Whom It May Concern:

I am writing on behalf of my patient, [Patient Name], to formally document the medical necessity for [Name of Treatment, Procedure, or Equipment]. [Patient Name] has been under my care for [Diagnosis/Condition] (ICD-10 Code: [Code]) since [Date].

Clinical History and Diagnosis:
[Patient Name] presents with [List symptoms, severity, and duration]. Current clinical findings include [List physical exam results or lab data].

Previous Treatments:
The patient has previously attempted the following treatments which were unsuccessful or contraindicated:

- [Treatment A]: [Duration/Outcome]
- [Treatment B]: [Duration/Outcome]

Treatment Recommendation:
Based on the patient's medical history and current condition, I am prescribing [Requested Treatment/Equipment]. This intervention is medically necessary because [Explain how it treats the condition, prevents deterioration, or improves function].

Summary:
In my professional medical opinion, [Requested Treatment] is the most appropriate and effective course of action for this patient. Failure to provide this treatment may result in [List potential negative health outcomes].

Please contact my office at [Phone Number] if you require additional clinical documentation or have further questions.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number / NPI Number]