

Date: [Insert Date]

To: [Insurance Company Name]

Attention: [Prior Authorization/Medical Review Department]

Fax/Address: [Insert Fax Number or Address]

RE: Letter of Medical Necessity for Private Duty Nursing (PDN)

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

Member ID: [Insurance ID Number]

Policy/Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request the authorization of Private Duty Nursing (PDN) services for [Patient Name]. I am [Patient Name]'s primary treating [Physician/Specialist], and I have been managing their care since [Date].

Medical Diagnosis and History:

[Patient Name] is a [Age]-old child diagnosed with the following medical conditions:

- [Diagnosis 1, ICD-10 Code]
- [Diagnosis 2, ICD-10 Code]
- [Diagnosis 3, ICD-10 Code]

Clinical Justification for In-Home Nursing:

The patient is medically fragile and requires continuous, skilled nursing intervention that cannot be provided by a non-medical caregiver. [Patient Name] requires the following skilled treatments:

- [Example: Ventilator management and frequent suctioning]
- [Example: Tracheostomy care and emergency airway management]
- [Example: Enteral feedings via G-tube/J-tube with complex medication administration]
- [Example: Continuous pulse oximetry monitoring and oxygen titration]
- [Example: Management of frequent, uncontrolled seizure activity]

Request for Services:

Based on the patient's clinical instability and the complexity of their care, I am prescribing skilled nursing services for [Number] hours per day, [Number] days per week. These services are medically necessary to prevent frequent hospitalizations, emergency room visits, and life-threatening complications.

In my professional medical opinion, the requested nursing hours are essential to ensure the safety and health of [Patient Name] within the home environment. Without this level of care, the patient would require placement in an acute care facility or long-term pediatric nursing facility.

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

Sincerely,

[Physician Signature]

[Physician Printed Name]

[NPI Number]

[Medical Practice Name]