Date: [Insert Date]

TO: [Insurance Company Name]
ATTN: [Department/Contact Person]
FAX/ADDRESS: [Insert Fax Number or Address]

RE: Letter of Medical Necessity for Private Duty Nursing / In-Home Nursing Management
PATIENT NAME: [Patient First and Last Name]
DATE OF BIRTH: [MM/DD/YYYY]
POLICY NUMBER: [Insert Number]
GROUP NUMBER: [Insert Number]

To Whom It May Concern,

I am writing to formally request authorization for skilled in-home nursing management for my patient, [Patient Name]. [Patient Name] is currently under my care for the management of the following chronic conditions:

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

Clinical Justification:
The patient's condition is characterized by [List complications, e.g., frequent exacerbations, respiratory instability, or neurological impairment]. Due to the complexity of the treatment regimen, the patient requires continuous assessment and intervention by a licensed nurse (RN/LPN) to prevent life-threatening complications and frequent hospitalizations.

Required Skilled Interventions:
The following skilled nursing tasks are medically necessary and cannot be performed by non-medical personnel:

- [E.g., Management and titration of intravenous medications]
- [E.g., Ventilator or tracheostomy care and suctioning]
- [E.g., Complex wound care or enteral feeding management]
- [E.g., Frequent monitoring of vital signs to adjust pharmacological interventions]

Requested Services:
I am prescribing [Number of Hours] hours per day, [Number of Days] days per week of skilled in-home nursing care for an initial period of [Duration, e.g., 6 months].

In my professional medical opinion, in-home nursing management is the least restrictive and most cost-effective environment for this patient. Without this level of care, [Patient Name] is at high risk for acute clinical deterioration and emergency department readmission.

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

Sincerely,

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