Date: [Date]

TO: [Insurance Company Name]
ATTN: [Appeals/Authorization Department]
FAX/ADDRESS: [Fax Number or Address]

RE: Letter of Medical Necessity for In-Home Palliative Nursing Care
PATIENT NAME: [Patient Name]
DATE OF BIRTH: [DOB]
POLICY NUMBER: [Policy ID]
GROUP NUMBER: [Group Number]
CLAIM/REFERENCE NUMBER: [Reference Number if applicable]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to formally request coverage for in-home palliative nursing care. [Patient Name] has been diagnosed with [Primary Diagnosis] and [Secondary Diagnoses/Comorbidities].

The patient's current clinical status includes:

- [Describe current symptoms, e.g., chronic pain, respiratory distress, etc.]
- [Describe functional limitations, e.g., bedbound, assistance with ADLs]
- [Describe recent hospitalizations or ER visits related to the condition]

Based on the complexity of the patient's symptoms and the progression of their illness, in-home palliative nursing care is medically necessary to:

- Provide advanced pain and symptom management to prevent unnecessary hospital readmissions.
- Monitor medication administration and titration for high-risk clinical needs.
- Provide skilled nursing assessments to manage [Specific Medical Issue, e.g., wound care, oxygen titration].
- Coordinate care between specialists to improve the patient's quality of life and minimize acute crises.

The requested services include [Number of hours/days per week] of skilled nursing care. Without these services, the patient is at a high risk for acute complications requiring emergency intervention and inpatient hospitalization.

I have attached [Medical Records/Clinical Notes/Test Results] to support this request. Please contact my office at [Phone Number] if you require further information.

Sincerely,

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