

[Physician Date]
[Patient Name]
[Patient Date of Birth]
[Insurance Member ID Number]

To: [Insurance Company Name]
Attention: Medical Review/Prior Authorization Department
[Insurance Company Address]

Subject: Letter of Medical Necessity for In-Home High-Risk Maternity Nursing Services

To Whom It May Concern,

I am writing to formally request authorization for in-home high-risk maternity nursing services for my patient, [Patient Name], who is currently [Number] weeks pregnant. Based on her clinical presentation and medical history, these services are medically necessary to prevent maternal and fetal complications, including preterm birth and hospitalization.

Clinical Diagnosis and Medical History:

The patient has been diagnosed with the following high-risk conditions:

- [Condition 1, e.g., Preeclampsia]
- [Condition 2, e.g., Gestational Diabetes]
- [Condition 3, e.g., History of Preterm Labor]

Treatment Plan and Necessity:

Due to these conditions, the patient requires frequent clinical monitoring that cannot be safely managed through office visits alone. In-home nursing services are required to provide:

- Skilled nursing assessments and vital sign monitoring (BP, heart rate).
- Fetal heart tone monitoring and uterine activity assessment.
- Medication administration and compliance tracking.
- Education on signs and symptoms of worsening condition to avoid emergency room visits.

Required Duration and Frequency:

I am prescribing in-home nursing visits [Number] times per week for a duration of [Number] weeks, or until the time of delivery.

Without these specialized home services, the patient is at significantly increased risk for [List specific risks, e.g., eclampsia, placental abruption, or fetal distress].

Please contact my office at [Phone Number] if you require additional medical records or clinical documentation.

Sincerely,

[Physician Signature]
[Physician Printed Name]

[Medical License Number/NPI]
[Practice Name]