

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

RE: Letter of Medical Necessity for Private Duty Nursing

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Policy/Member ID: [ID Number]

Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally document the medical necessity for continuous, in-home Private Duty Nursing (PDN) services for [Patient Name]. [Patient Name] is currently under my care for the management of [Primary Diagnosis, e.g., Chronic Respiratory Failure] and is fully dependent on mechanical ventilation.

Clinical Status and Diagnosis:

The patient suffers from [List Diagnoses, e.g., Neuromuscular Disease, Spinal Cord Injury, Bronchopulmonary Dysplasia]. Due to these conditions, the patient requires a life-sustaining mechanical ventilator for [Number] hours per day via [Tracheostomy/Mask].

Required Nursing Interventions:

Because of ventilator dependency, the patient requires frequent and complex skilled nursing interventions that cannot be safely performed by non-medical personnel, including:

- Continuous monitoring of respiratory status and ventilator settings.
- Frequent tracheal suctioning to maintain airway patency.
- Emergency intervention in the event of accidental decannulation or ventilator failure.
- Administration of nebulized medications and chest physiotherapy.
- Management of [Insert other needs, e.g., Enteral feeding, Medication titration].

Medical Necessity:

Continuous skilled nursing is required to prevent life-threatening complications, respiratory distress, and frequent hospitalizations or emergency room visits. Without professional in-home nursing care, the patient's safety is severely compromised, as they lack the physical ability to clear their own airway or troubleshoot equipment failure.

Based on the patient's clinical profile, I am prescribing [Number] hours per day of skilled nursing care (RN/LPN). This level of care is essential to maintain the patient's stability in the home environment.

Please contact my office at [Phone Number] if further documentation or clinical records are required.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]