

[Physician Name]
[Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Insurance Company Name]
[Attn: Medical Review/Prior Authorization Department]
[Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for In-Home Nursing Services

Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request the authorization of skilled in-home nursing services for my patient, [Patient Name], who is currently under my care for the management of [Type 1 / Type 2] Diabetes Mellitus (ICD-10 Code: [Code]).

Despite current outpatient management, the patient remains at high risk for acute diabetic complications. Skilled nursing intervention is medically necessary due to the following factors:

- **Unstable Blood Glucose Levels:** The patient experiences frequent episodes of [hypoglycemia/hyperglycemia/brittle diabetes] that require professional clinical assessment.
- **Cognitive or Physical Limitations:** The patient is unable to independently [perform glucose testing / calculate insulin dosages / administer injections] due to [specify condition, e.g., neuropathy, retinopathy, or cognitive impairment].
- **Medication Adjustment:** Ongoing monitoring is required to safely titrate [Insulin/Non-insulin injectables] and prevent life-threatening events such as diabetic ketoacidosis (DKA).
- **Comorbidities:** The patient's condition is further complicated by [List comorbidities, e.g., Chronic Kidney Disease, Hypertension].

The requested in-home nursing services will include regular glucose monitoring, medication administration, assessment of skin integrity/diabetic foot care, and caregiver education to stabilize the patient's condition and prevent emergency room visits or hospitalizations.

I am requesting [Number] hours per day, [Number] days per week of [RN/LPN] services for an initial period of [Duration].

Please contact my office at [Phone Number] if you require additional medical records or documentation to support this request.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]