

**Date:** [Insert Date]

**TO:** [Insurance Company Name]

**ATTN:** [Appeals/Medical Review Department]

**FAX/ADDRESS:** [Insert Fax Number or Address]

**RE:** Letter of Medical Necessity for In-Home Nursing Care

**Patient Name:** [Patient Full Name]

**Date of Birth:** [Patient DOB]

**Policy Number:** [Member ID Number]

**Group Number:** [Group Number]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to formally request coverage for skilled in-home nursing care. [Patient Name] is currently under my care for [Specific Diagnosis/Type of Cancer], Stage [Stage].

**Clinical Background:**

The patient is currently undergoing intensive treatment, including [List treatments, e.g., Chemotherapy, Radiation, Post-Surgical Care]. As a result of these interventions and the underlying malignancy, the patient is experiencing [List symptoms/complications, e.g., severe immunosuppression, wound care requirements, malnutrition, risk of sepsis, or functional decline].

**Medical Necessity:**

In-home nursing care is medically necessary for this patient to:

- Administer and monitor parenteral medications and IV fluids.
- Perform complex wound care and dressing changes for [Specify site].
- Monitor for life-threatening complications related to [Specific treatment].
- Provide skilled assessment of vitals and laboratory trends to prevent avoidable hospital readmissions.
- Manage specialized equipment such as [e.g., PICC line, Port-a-cath, or Feeding tube].

**Treatment Plan:**

I am recommending skilled nursing visits [Number of hours/days per week] for a duration of [Number of weeks/months]. This level of care is required because the patient is currently homebound and unable to safely travel to a clinic daily for these specific interventions.

Failure to provide these services would place the patient at significant risk for infection, dehydration, and acute clinical deterioration. Please contact my office at [Phone Number] if you require further documentation or clinical notes.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Medical Facility Name]