Date: [Date]

TO: [Insurance Company Name]
ATTN: Appeals/Medical Review Department
ADDRESS: [Insurance Address]

RE: Letter of Medical Necessity for Custom Functional Orthotics
PATIENT NAME: [Patient Full Name]
DATE OF BIRTH: [DOB]
POLICY ID: [Insurance ID Number]
CLAIM/REFERENCE #: [If applicable]

To Whom It May Concern,

I am writing to formally document the medical necessity for custom-molded orthotics (HCPCS Code: L3000) for the above-referenced patient. [Patient Name] is currently under my care for the management of complications related to Diabetes Mellitus.

Diagnosis:

- Primary Diagnosis: [e.g., E11.621 - Type 2 diabetes mellitus with foot ulcer]
- Secondary Diagnosis: [e.g., E11.40 - Type 2 diabetes mellitus with neurological complications / Peripheral Neuropathy]
- Additional Findings: [e.g., Foot deformity, Charcot foot, or history of amputation]

Clinical Findings:

Upon physical examination, the patient presents with [describe ulcer location and stage]. The patient also exhibits [describe physical symptoms, e.g., loss of protective sensation, structural deformities, or gait abnormalities]. These conditions significantly increase the risk of recurrent ulceration, infection, and potential lower extremity amputation.

Medical Necessity:

Custom orthotics are required in this case to provide total contact redistribution of pressure away from the ulcerated site and bony prominences. Prefabricated inserts are insufficient because they do not account for the patient's unique foot morphology and the specific location of the wound. The goal of this treatment is to facilitate wound healing, prevent future skin breakdown, and maintain the patient's mobility.

Treatment Plan:

The prescribed custom orthotics are an integral part of this patient's diabetic foot care regimen. Failure to provide these devices places the patient at high risk for hospitalization and surgical intervention.

I request that you approve coverage for these medically necessary devices. Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DPM]
NPI: [NPI Number]
Practice Name: [Clinic Name]