

**Date:** [Date]

**TO:** [Insurance Company Name]

**ATTN:** Claims/Appeals Department

**ADDRESS:** [Insurance Company Address]

**RE: Letter of Medical Necessity for Custom Functional Orthotics**

**PATIENT NAME:** [Patient Full Name]

**DATE OF BIRTH:** [Patient DOB]

**POLICY ID:** [Member ID Number]

**GROUP NUMBER:** [Group Number]

To Whom It May Concern,

I am writing to formally request coverage for custom-molded functional foot orthotics (HCPCS Code: L3000) for the above-referenced patient. The patient has been under my care for chronic foot pain and has been diagnosed with:

- **Primary Diagnosis:** Plantar Fasciitis (ICD-10: M72.2)
- **Secondary Diagnosis:** [e.g., Pes Planus / Excessive Pronation]

**Clinical Findings:**

The patient presents with significant pain localized to the [Left/Right/Bilateral] heel and medial longitudinal arch. Physical examination reveals [describe findings, e.g., point tenderness at the calcaneal tuberosity and tight Achilles tendons]. Biomechanical evaluation indicates [describe, e.g., abnormal gait or collapsing arches] which exacerbates the inflammatory condition.

**Conservative Treatments Attempted:**

The patient has attempted the following conservative treatments without adequate long-term relief:

- Over-the-counter arch supports/inserts
- Prescription NSAIDs and topical analgesics
- Specific stretching and physical therapy exercises
- Activity modification

**Medical Necessity:**

Custom orthotics are medically necessary for this patient to provide specific structural support, redistribute pressure away from the plantar fascia, and correct the underlying biomechanical imbalances. Without these custom-molded devices, the patient's condition is likely to worsen, potentially leading to further mobility limitations, chronic inflammation, or the need for more invasive surgical intervention.

I am prescribing custom-molded orthotics to allow the patient to return to normal daily activities and prevent further injury. Please approve coverage for these essential medical devices.

Sincerely,

[Physician Signature]

**[Physician Name, Degree]**

**NPI Number:** [NPI Number]

**Practice Name:** [Clinic Name]

**Phone:** [Phone Number]