

Date: [Date]

To: [Insurance Company Name]

Attention: Claims/Appeals Department

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Policy Number: [Policy ID]

Group Number: [Group ID]

Subject: Letter of Medical Necessity for Custom Functional Orthotics

To Whom It May Concern,

I am writing to formally request coverage for custom-molded functional orthotics (HCPCS Code: L3000) for the above-mentioned patient. This request is based on the patient's current sports-related injury and the clinical necessity for biomechanical stabilization during rehabilitation.

Clinical Diagnosis:

The patient presents with [Specific Diagnosis, e.g., Grade II Medial Collateral Ligament Sprain, Plantar Fasciitis, or Tibial Stress Syndrome]. ICD-10 Code(s): [Insert Codes].

Clinical Findings and History:

The patient sustained this injury on [Date] during [Type of Sport/Activity]. Physical examination reveals [Brief Findings, e.g., excessive pronation, limb length discrepancy, or joint instability]. These biomechanical abnormalities are directly contributing to the patient's pain and delaying the recovery of the injured tissue.

Medical Necessity:

Custom orthotics are required for this patient to:

- Provide structural alignment to prevent further injury to [Injured Area].
- Distribute weight-bearing forces evenly across the lower extremities during the gait cycle.
- Facilitate a safe return to physical therapy and sports-specific rehabilitation exercises.
- Reduce mechanical stress on tendons and ligaments during the healing phase.

Alternative Treatments:

Conservative treatments, including [List treatments, e.g., rest, ice, over-the-counter inserts, or physical therapy], have been utilized. However, without the precise corrective support of custom orthotics, the patient remains at high risk for chronic instability or reinjury.

Duration of Use:

The patient is expected to require these orthotics for [Estimated Duration, e.g., 12-24 months] to ensure full rehabilitation and long-term joint protection.

Please contact my office at [Phone Number] if further documentation is required for the approval of this essential medical equipment.

Sincerely,

[Physician Signature]

[Physician Name, Degree]

[NPI Number]

[Clinic Name]