

Date: [Insert Date]

To: [Insurance Company Name]

Attention: Medical Review/Appeals Department

Address: [Insert Address]

Fax/Phone: [Insert Fax/Phone Number]

RE: Letter of Medical Necessity

Patient Name: [Patient First and Last Name]

Date of Birth: [MM/DD/YYYY]

Policy Number: [Insert Number]

Group Number: [Insert Number]

To Whom It May Concern,

I am writing to formally request coverage for custom-molded orthotics and specialized footwear for the above-mentioned patient. This equipment is medically necessary for the treatment and management of **Charcot Neuroarthropathy (Charcot Foot)**, ICD-10 Code: [Insert Code, e.g., M14.67].

Clinical Diagnosis and History:

The patient presents with severe structural deformity of the [Left/Right/Bilateral] foot resulting from Charcot Neuroarthropathy. This condition has caused significant bone fragmentation, joint dislocation, and collapse of the midfoot arch ("rocker-bottom" deformity). The patient also suffers from [List comorbidities, e.g., peripheral neuropathy and Type 2 Diabetes].

Medical Necessity:

Standard over-the-counter inserts are insufficient to address this patient's clinical needs. The requested custom orthotics are required to:

- Redistribute plantar pressure to prevent skin breakdown and chronic ulceration.
- Stabilize the weakened joints and prevent further osseous destruction.
- Provide structural support to the collapsed arch to allow for safe ambulation.
- Reduce the high risk of infection and lower-extremity amputation associated with this deformity.

Requested Equipment:

[Insert Specific HCPCS Codes, e.g., L3000, L3250] - [Description of specific orthotic or shoe modification].

In my professional medical opinion, these orthotics are the least restrictive and most effective treatment to maintain this patient's mobility and prevent catastrophic complications. Failure to provide this equipment will likely result in surgical intervention or hospitalization.

Please contact my office at [Insert Phone Number] if you require additional clinical documentation or imaging reports.

Sincerely,

[Physician Signature]

[Physician Name, MD/DPM]

[NPI Number]

[Practice Name]