

[Physician Name]  
[Clinic Name]  
[Address]  
[City, State, Zip]  
[Phone Number]  
[Date]

[Insurance Company Name]  
[Attention: Appeals/Medical Review Department]  
[Address]  
[City, State, Zip]

**RE: Letter of Medical Necessity for Custom Orthotic**

**Patient Name:** [Patient Name]

**Date of Birth:** [DOB]

**Policy Number:** [Policy #]

**Group Number:** [Group #]

To Whom It May Concern,

I am writing to formally request coverage for a custom [Type of Orthotic, e.g., Ankle Foot Orthosis/AFO] for my patient, [Patient Name].

**Diagnosis:**

The patient has a diagnosis of Congenital Limb Discrepancy (ICD-10: [Code, e.g., Q72.819]). Specifically, the patient presents with a length difference of [Number] cm between the [Left/Right] and [Left/Right] limb.

**Clinical Findings:**

Due to this congenital condition, the patient exhibits [List symptoms, e.g., pelvic tilt, compensatory scoliosis, gait instability, and frequent falls]. Physical examination reveals significant mechanical strain on the musculoskeletal system.

**Medical Necessity:**

The requested custom orthotic is medically necessary to:

- Equalize limb length and restore pelvic alignment.
- Prevent long-term secondary deformities of the spine and hips.
- Improve gait efficiency and reduce the risk of injury from instability.
- Allow the patient to perform Activities of Daily Living (ADLs) without pain.

**Treatment Plan:**

Off-the-shelf solutions are insufficient for this patient due to the specific [Degree/Nature] of the discrepancy and the need for precise biomechanical correction. The patient is to wear this custom device [Frequency, e.g., daily during all weight-bearing activities].

Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician Signature]

[Physician Name, Title]

[NPI Number]