

Date: [Date]
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Policy Number: [Policy ID/Number]
Group Number: [Group Number]

To: [Insurance Company Name]
Department: Claims/Appeals Department

Subject: Letter of Medical Necessity for Custom Functional Orthotics

To Whom It May Concern,

I am writing to formally request coverage for custom functional foot orthotics (HCPCS Code L3000) for the above-referenced patient. [Patient Name] is currently under my care for the treatment of **Chronic Achilles Tendonitis (ICD-10: M76.60)**.

Clinical Diagnosis and History:

The patient presents with persistent pain, inflammation, and reduced range of motion in the [Left/Right/Both] Achilles tendon lasting for [Number] months/years. Clinical evaluation reveals significant biomechanical abnormalities, specifically [e.g., excessive pronation or equinus deformity], which places excessive mechanical strain on the Achilles tendon during the gait cycle.

Treatment History:

Prior to this recommendation, the patient has attempted conservative treatments including:

- Physical therapy
- Non-steroidal anti-inflammatory drugs (NSAIDs)
- Rest, Ice, Compression, and Elevation (RICE)
- Over-the-counter (OTC) inserts (which provided insufficient support)

Despite these interventions, the patient continues to experience chronic pain that interferes with daily activities.

Medical Necessity:

Custom orthotics are medically necessary for this patient to provide specific longitudinal arch support and heel elevation. These devices will realign the hindfoot, reduce the tension on the Achilles tendon, and prevent further micro-tearing or potential rupture. Without these custom-molded devices, the patient is at high risk for permanent tendon degeneration and may require surgical intervention.

I certify that the prescribed custom orthotics are not for convenience or comfort, but are an essential component of the patient's medical treatment plan.

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

Sincerely,

[Doctor's Signature]

[Doctor's Printed Name, Degree]

[NPI Number]

[Practice Name]