

**Date:** [Date]

**TO:** [Insurance Company Name]

**ATTN:** [Department/Claims Department]

**FAX/ADDRESS:** [Fax Number or Mailing Address]

**RE: Letter of Medical Necessity for Nutritional Counseling**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [Patient DOB]

**Member ID:** [Insurance ID Number]

**Group Number:** [Group Number]

To Whom It May Concern,

I am writing to formally request coverage for Medical Nutrition Therapy (MNT) and nutritional counseling services for my patient, [Patient Name]. These services are medically necessary for the management of the patient's current health condition(s).

**Diagnosis and Clinical Information:**

- Primary Diagnosis: [Diagnosis Name] (ICD-10 Code: [Code])
- Secondary Diagnosis: [Diagnosis Name] (ICD-10 Code: [Code])
- Current BMI: [BMI Value]
- Relevant Lab Results: [Insert pertinent labs such as A1C, Lipid Panel, etc.]

**Treatment Plan:**

The patient requires professional dietary intervention provided by a Registered Dietitian (RD/RDN). This treatment is essential to [state goal, e.g., stabilize blood sugar, prevent cardiovascular complications, manage gastrointestinal symptoms]. Nutritional counseling will provide the patient with the specific skills, education, and monitoring required to manage their condition and prevent further medical complications or hospitalizations.

**Recommended Frequency:**

I am prescribing [Number] sessions of nutritional counseling over the next [Number] months.

Given the patient's clinical history and diagnosis, I request that you approve coverage for these services. Please contact my office at [Phone Number] if you require any additional documentation.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[NPI Number]  
[Practice Name]