[Physician Name]
[Practice/Facility Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Insurance Company Name]
[Attn: Medical Review/Prior Authorization Department]
[Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Hyperbaric Oxygen Therapy (HBOT)
Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group ID]
ICD-10 Code(s): [e.g., E11.621, L97.419]

To Whom It May Concern,

I am writing to formally request authorization for Hyperbaric Oxygen Therapy (HBOT) for [Patient Name] to treat a chronic, non-healing diabetic foot ulcer. Based on the patient's clinical history and lack of progress with standard wound care, I have determined that HBOT is a medically necessary intervention to prevent further complications, such as gangrene or lower extremity amputation.

Clinical Documentation:

- **Diagnosis:** The patient has Type [1/2] Diabetes Mellitus with a Wagner Grade [3 or 4] ulcer located on the [Specific Location, e.g., left plantar surface].
- **Duration:** The wound has been present for [Number] weeks/months.
- **Previous Treatments:** To date, the patient has undergone at least 30 days of standard wound care, including [list treatments, e.g., surgical debridement, off-loading, moist wound dressings, and antibiotic therapy].
- **Response:** Despite these conservative measures, there has been no measurable signs of healing or significant reduction in wound size.

Treatment Plan:

I am prescribing a course of HBOT consisting of [Number, e.g., 30-40] sessions at [Pressure, e.g., 2.0 ATA] for [Duration, e.g., 90 minutes] per session. This treatment is intended to increase tissue oxygenation, stimulate angiogenesis, and enhance the bactericidal activity of leukocytes in the affected area.

In my professional medical opinion, HBOT is the most appropriate next step in this patient's care to ensure limb salvage. Failure to provide this treatment places the patient at a significantly higher risk for hospital admission and surgical amputation.

Please contact my office at [Phone Number] if you require additional medical records or have questions regarding this request.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[NPI Number]