Date: [Date]

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

RE: Letter of Medical Necessity for Hyperbaric Oxygen Therapy (HBOT)

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group Number]
ICD-10 Code(s): [e.g., L59.8, K62.7, N30.40]

Dear Medical Director,

I am writing to formally request authorization for Hyperbaric Oxygen Therapy (HBOT) for the above-referenced patient. This treatment is medically necessary for the management of **Delayed Radiation Tissue Injury (Soft Tissue/Bone Radionecrosis)** resulting from prior radiation therapy for [Type of Cancer].

Clinical History:
The patient completed radiation therapy on [Date]. They currently present with [List symptoms, e.g., non-healing radiation ulcers, chronic bleeding, cystitis, or proctitis]. These symptoms have persisted for [Duration] and significantly impact the patient's quality of life and functional status.

Previous Treatments Attempted:
The following conservative treatments have been attempted without successful resolution of the injury:

- [Treatment 1, e.g., Specialized wound care dressings]
- [Treatment 2, e.g., Oral medications/Antibiotics]
- [Treatment 3, e.g., Surgical debridement]

Rationale for HBOT:
Delayed radiation tissue injury is characterized by hypocellular, hypovascular, and hypoxic tissue. HBOT is the only treatment modality proven to stimulate angiogenesis and fibroblast proliferation in irradiated tissue by increasing the oxygen tension gradient. This therapy is essential to prevent further tissue necrosis and [potential complications, e.g., bone fracture, organ loss, or systemic infection].

Proposed Treatment Plan:
I am prescribing [Number, e.g., 30 to 40] sessions of HBOT at [Pressure, e.g., 2.0 or 2.4] ATA for [Duration, e.g., 90 minutes] per day, five days per week. The patient will be reassessed every 20 treatments to monitor progress.

Please contact my office at [Phone Number] if you require additional medical records or clinical documentation to support this request.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Specialty, e.g., Wound Care/Hyperbaric Medicine]
[NPI Number]
[Facility Name]