

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

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

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

**Patient Name:** [Patient Name]

**Date of Birth:** [DOB]

**Policy ID:** [Policy ID Number]

**Claim/Reference Number:** [Reference Number, if applicable]

To Whom It May Concern,

I am writing to formally request authorization for Hyperbaric Oxygen Therapy (HBOT) for the above-referenced patient, who has been diagnosed with Sudden Sensorineural Hearing Loss (SSNHL) (ICD-10 Code: H91.20).

**Clinical History:**

The patient presented on [Date] with a sudden loss of hearing in the [Left/Right] ear. Audiometric testing confirmed a hearing loss of at least [Number] decibels over at least three contiguous frequencies. This onset occurred [Number] days/weeks ago.

**Treatment to Date:**

To date, the patient has undergone the following treatments:

- [e.g., Oral Corticosteroids: Dose and Duration]
- [e.g., Intratympanic Steroid Injections: Dates and Frequency]

Despite these interventions, the patient continues to experience significant hearing deficits.

**Medical Necessity:**

According to the Clinical Practice Guidelines from the American Academy of Otolaryngology-Head and Neck Surgery, HBOT is a recommended treatment option for patients with SSNHL when initiated within the first 3 months of symptom onset. The rationale for HBOT in SSNHL is to increase the partial pressure of oxygen in the perilymph, thereby reversing hypoxia in the cochlea and promoting the recovery of damaged hair cells.

**Proposed Treatment Plan:**

I am prescribing a course of [Number, typically 10-20] HBOT sessions at [Pressure, e.g., 2.0 or 2.4 ATA] for 90 minutes each. We will re-evaluate hearing via audiogram after the initial 10 sessions to assess progress.

Given the critical window for potential recovery, I request an expedited review of this request. Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]