Date: [Date]

TO: [Insurance Company Name]
ATTN: [Appeals/Medical Review Department]
FAX: [Fax Number]

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

Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy ID: [Member ID]
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. This treatment is medically necessary due to the patient's diagnosis of **Acute Traumatic Ischemia and Crush Injury** (ICD-10 Code: [Insert Code, e.g., S37.9]).

Clinical Presentation:
The patient presented on [Date] following a [describe mechanism of injury, e.g., motor vehicle accident, machinery accident]. Examination revealed [list symptoms, e.g., severe edema, compromised capillary refill, loss of sensory/motor function, or non-palpable pulses].

Medical Justification:
Hyperbaric Oxygen Therapy is indicated in this case as an adjunct to surgical intervention and standard wound care. The rationale for treatment includes:

- Reduction of interstitial edema through hyperoxic vasoconstriction.
- Restoration of tissue oxygen tension in ischemic areas to promote cellular survival.
- Prevention of reperfusion injury by inhibiting lipid peroxidation and leukocyte adhesion.
- Enhancement of host defenses and antibiotic efficacy in compromised tissue.

Treatment Plan:
I am prescribing a course of HBOT at [Atmospheres Absolute, e.g., 2.0 or 2.5 ATA] for [Duration, e.g., 90 minutes]. Given the acute nature of this injury, the patient requires [Number] sessions per day for an initial period of [Number] days, followed by re-evaluation.

This treatment follows the Undersea and Hyperbaric Medical Society (UHMS) guidelines for the management of Crush Injury and Acute Traumatic Ischemia. Failure to provide this therapy puts the patient at high risk for tissue necrosis, compartment syndrome, and potential limb amputation.

If you require further documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Facility Name]