Date: [Date]

TO: [Insurance Company Name]
ATTN: Medical Review/Pre-authorization Department
FAX/ADDRESS: [Fax Number or Address]

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]
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 aforementioned patient, who is currently under my care for the management of severe thermal burns. Based on the clinical presentation and the specific nature of the injuries, I have determined that HBOT is a medically necessary intervention to prevent further tissue necrosis and optimize wound healing.

Clinical Diagnosis and History:
The patient sustained [Type of Burn, e.g., Second or Third Degree] thermal burns on [Date of Injury]. The affected areas include [List Body Parts] covering approximately [Percentage]% of the Total Body Surface Area (TBSA). Current assessment reveals [Describe current wound status, e.g., compromised perfusion, deepening of the burn wound, or stasis zone expansion].

Medical Necessity and Treatment Plan:
HBOT is indicated for this patient to address the following clinical objectives:

- Reduction of edema and improvement of microvascular perfusion in the zone of stasis.
- Enhancement of oxygen delivery to ischemic tissues to prevent the conversion of partial-thickness burns to full-thickness burns.
- Promotion of collagen synthesis and epithelialization.
- Reduction in the need for extensive surgical grafting and shortening of hospital stay.

Proposed Treatment Protocol:
I am prescribing a course of [Number] HBOT sessions at [Pressure, e.g., 2.0 or 2.4 ATA] for [Duration, e.g., 90 minutes] per session. Treatment will be administered [Frequency, e.g., twice daily for the first 24-48 hours, followed by once daily].

In my professional medical opinion, HBOT is essential to this patient's recovery and is the most effective treatment to mitigate permanent disability or extensive tissue loss. Failure to provide this therapy may result in [List risks, e.g., infection, graft failure, or extended surgical intervention].

Please find attached the clinical notes, burn maps, and relevant laboratory results supporting this request. Should you require additional information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical Specialty/Board Certification]
[NPI Number]
[Facility Name]