[Date]

[Insurance Company Name]
[Claims/Appeals Department]
[Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Hyperbaric Oxygen Therapy (HBOT)
Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Policy Number: [Policy ID Number]
Group Number: [Group Number]
ICD-10 Codes: [e.g., L59.8, K62.7, N32.81]

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 to manage chronic late effects of radiation, specifically [Radiation Proctitis and/or Radiation Cystitis].

Clinical History:
The patient underwent a course of radiation therapy for [Primary Cancer Diagnosis] on [Date]. Since then, the patient has developed significant complications characterized by [List symptoms, e.g., persistent rectal bleeding, hematuria, pelvic pain, urgency].

Previous Treatments:
The following conventional treatments have been attempted and failed to provide relief:
- [Treatment 1, e.g., Formalin application]
- [Treatment 2, e.g., Laser coagulation]
- [Treatment 3, e.g., Oral/Topical medications]

Medical Justification:
Radiation-induced tissue injury results in fibro-atrophic and hypocellular changes with associated endarteritis and local hypoxia. HBOT is the only treatment modality that stimulates angiogenesis and fibroblast proliferation in previously irradiated tissue. Based on the Undersea and Hyperbaric Medical Society (UHMS) guidelines and the CMS National Coverage Determination (NCD 20.29), HBOT is an indicated and effective treatment for delayed radiation injuries (Soft Tissue Radiation Necrosis).

Treatment Plan:
I am recommending a course of [Number] HBOT sessions at [Pressure, e.g., 2.0 or 2.4 ATA] for [Duration] minutes per day. The patient will be monitored for clinical improvement in [bleeding/tissue integrity/pain] throughout the course of therapy.

Please contact my office at [Phone Number] if you require further documentation or clinical notes.

Sincerely,

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