

Date: [Insert Date]

RE: Letter of Medical Necessity for Compression Garments

Patient Name: [Insert Patient Full Name]

Date of Birth: [Insert DOB]

Policy Number: [Insert Insurance Policy Number]

Group Number: [Insert Group Number]

To Whom It May Concern,

I am writing to formally authorize and request coverage for post-surgical medical-grade compression garments for the above-named patient. The patient underwent [Insert Name of Surgical Procedure] on [Insert Date of Surgery].

Clinical Justification:

The use of medical-grade compression (specifically [Insert Compression Level, e.g., 20-30 mmHg]) is a critical component of this patient's postoperative treatment plan. These garments are medically necessary to:

- Reduce postoperative edema (swelling) and lymphedema.
- Prevent the formation of hematomas and seromas.
- Support surgical site integrity and promote proper wound healing.
- Minimize the risk of Deep Vein Thrombosis (DVT).
- Provide essential stabilization of soft tissue during the recovery phase.

Prescription Details:

Item: [Insert Specific Garment Type, e.g., Abdominal Binder, Compression Stockings, or Full Body Suit]

Quantity: [Insert Number, e.g., 2 garments - one to wear, one to wash]

Duration: [Insert Duration, e.g., 6-12 weeks]

Please process this claim as a medical necessity rather than a cosmetic or elective accessory. Should you require further clinical documentation or operative reports, please contact my office at [Insert Phone Number].

Sincerely,

[Physician Signature]

Physician Name: [Insert Name]

NPI Number: [Insert NPI]

Practice Name: [Insert Clinic/Hospital Name]