

[Date]

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

RE: Letter of Medical Necessity for Compression Garments

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Member ID: [Insurance ID Number]

Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally document the medical necessity of custom-fit compression garments for the above-mentioned patient. [Patient Name] is currently under my care for the treatment and management of burn injuries sustained on [Date of Injury].

Clinical Diagnosis:

The patient has sustained [Percentage]% Total Body Surface Area (TBSA) burns, specifically involving [List Body Areas, e.g., arms, torso, legs]. The wounds are currently categorized as [Grade/Severity, e.g., deep partial-thickness/full-thickness] burns.

Medical Necessity:

The patient is at high risk for developing hypertrophic scarring and joint contractures. Medical-grade compression garments (providing 20-30 mmHg of pressure) are the gold standard of care for burn scar maturation. These garments are required to:

- Control and flatten hypertrophic scar tissue.
- Provide vascular support and reduce edema in healing tissue.
- Protect fragile newly healed skin/skin grafts from mechanical trauma.
- Maintain range of motion and prevent functional impairment.

Prescription:

I am prescribing the following durable medical equipment (DME):

[List Specific Garments, e.g., Custom Jobst pressure vest, custom gauntlets, etc.]

Quantity: [Number] sets (one to wear, one to wash) to ensure 23-hour daily compliance.

Failure to provide these garments will likely result in permanent physical deformity and the need for future surgical scar revisions. Please approve coverage for these essential medical supplies.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Medical License/NPI Number]

[Facility/Clinic Name]
[Phone Number]