Date: [Date]

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Policy Number: [Insurance Policy Number]
Provider Group: [Provider Name/Clinic]

To Whom It May Concern,

I am writing to provide medical necessity documentation for [Patient Name], who is currently under my care for pregnancy. The patient's estimated date of delivery is [EDD].

The patient is experiencing the following condition(s):

- [e.g., Severe Varicose Veins]
- [e.g., Chronic Venous Insufficiency]
- [e.g., Lymphedema or Edema]
- [e.g., Pelvic Girdle Pain / Symphysis Pubis Dysfunction]

As part of the treatment plan, I am prescribing a **Medical Grade Compression Garment** (HCPCS Code: [e.g., A6530 / A6545 / E1399]) with a compression rating of [e.g., 20-30 mmHg].

This garment is medically necessary to:

- Reduce lower extremity swelling and edema.
- Prevent deep vein thrombosis (DVT).
- Provide abdominal and pelvic support to stabilize the musculoskeletal system.
- Improve venous return and circulation.

Please approve coverage for this medical device as prescribed. If you require further documentation, please contact our office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, Title]
NPI Number: [NPI Number]
Clinic Name: [Clinic Name]