

Date: [Date]

To: [Insurance Company Name]
Attn: Claims/Medical Review Department
Address: [Insurance Company Address]

Subject: Letter of Medical Necessity for Compression Garments

Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy Number: [Policy Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request coverage for medical-grade compression garments for my patient, [Patient Name], who is currently under my care for the treatment of Peripheral Edema (ICD-10 Code: [Insert Code, e.g., R60.0]).

The patient presents with persistent swelling in the [Location, e.g., bilateral lower extremities] which has not responded adequately to conservative management alone. Clinical evaluation confirms that medical-grade compression is a therapeutic necessity to manage fluid volume, improve venous return, and prevent complications such as skin breakdown, cellulitis, or ulceration.

I am prescribing the following:

- Type of Garment: [e.g., Knee-high stockings, Thigh-high stockings]
- Compression Level: [e.g., 20-30 mmHg, 30-40 mmHg]
- Quantity: [Number] pairs

These garments are not for comfort or aesthetic purposes; they are a primary component of the medical treatment plan for chronic Peripheral Edema. Failure to utilize these garments puts the patient at high risk for worsening morbidity and potential hospitalization.

Please approve the coverage for these essential medical supplies. If you require further clinical documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Name, MD/DO]
[NPI Number]
[Practice Name]