Date: [Date]

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

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

Subject: Letter of Medical Necessity for Gradient Compression Garments

To Whom It May Concern,

I am writing to request coverage for medical-grade gradient compression garments for [Patient Name]. I have diagnosed the patient with severe varicose veins and chronic venous insufficiency (ICD-10 Code: [Insert Code, e.g., I83.90]).

Clinical Documentation:
The patient presents with the following symptoms and physical findings:
- [List symptoms: e.g., severe edema, skin discoloration, aching, heaviness]
- [List complications: e.g., history of venous ulcers, superficial thrombophlebitis]

Treatment History:
The patient has attempted conservative management including [list attempts: e.g., leg elevation, exercise, weight management] for a period of [number] months without sufficient relief of symptoms.

Prescription:
I am prescribing gradient compression stockings with a pressure rating of [Insert Pressure, e.g., 30-40 mmHg]. These garments are medically necessary to:
- Reduce venous stasis and lower extremity edema.
- Prevent the progression of skin breakdown and venous ulceration.
- Manage chronic pain and reduce the risk of deep vein thrombosis (DVT).

In my professional medical opinion, these garments are not for cosmetic purposes but are a vital component of the patient's medical treatment plan. Please approve the coverage for [Number] pairs of garments per year to ensure patient compliance and hygiene.

Should you require further clinical records, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

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