

[Date]

To: [Insurance Company Name]
Attn: Medical Review/Appeals Department
[Insurance Address]
[City, State, Zip]

RE: Letter of Medical Necessity for Compression Garments

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Member ID: [ID Number]

Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally document the medical necessity for medical-grade compression garments for the above-referenced patient. [Patient Name] is currently under my care at [Clinic Name] for the treatment of symptomatic chronic venous disease.

Diagnosis:

- [ICD-10 Code] - Chronic Venous Insufficiency (CVI)
- [ICD-10 Code] - Varicose veins of lower extremities with inflammation/ulcer
- [ICD-10 Code] - Lymphedema
- [ICD-10 Code] - Post-thrombotic syndrome

Clinical Findings:

The patient presents with clinical symptoms including [edema, skin changes, aching, heaviness, or venous ulcers]. Diagnostic ultrasound performed on [Date] confirmed [reflux/obstruction] in the [Specific Vein].

Prescribed Treatment:

I have prescribed the following medical-grade compression garments:

- **Compression Level:** [e.g., 20-30 mmHg / 30-40 mmHg]
- **Style:** [e.g., Knee-high, Thigh-high, or Pantyhose]
- **Quantity:** [e.g., 2-4 pairs per year]

Medical Necessity:

These garments are a critical component of the patient's treatment plan. They are required to increase venous return, decrease hydrostatic pressure, and prevent the progression of skin breakdown or recurrent ulceration. Without the use of these garments, the patient is at high risk for worsening edema, deep vein thrombosis (DVT), and cellulitis.

Please approve coverage for these durable medical equipment (DME) items as they are medically necessary for the management of this patient's condition.

Sincerely,

[Physician Signature]

[Physician Printed Name], [Credentials]

[NPI Number]

[Clinic Name]

[Phone Number]