Date: [Date]

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

RE: Letter of Medical Necessity for Cranial Remolding Orthosis
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Policy Number: [Policy ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number if applicable]

To Whom It May Concern,

I am writing to formally document the medical necessity for a custom Cranial Remolding Orthosis (HCPCS Code S1040) for my patient, [Patient Name].

Diagnosis:
The patient has been diagnosed with the following condition(s):
[ ] Deformational Plagiocephaly (ICD-10: Q67.3)
[ ] Deformational Brachycephaly (ICD-10: Q67.2)
[ ] Deformational Dolichocephaly (ICD-10: Q67.4)
[ ] Post-Surgical Craniosynostosis (ICD-10: Q75.0)

Clinical Findings:
Clinical assessment and anthropometric measurements performed on [Date] reveal the following:
- Cranial Vault Asymmetry (CVA): [Measurement in mm]
- Cephalic Index (CI): [Percentage %]
- Presence of: [e.g., Ear shift, frontal bossing, facial asymmetry]

History of Conservative Treatment:
Prior to this recommendation, the patient has undergone a [Number]-week period of conservative repositioning therapy and/or physical therapy beginning on [Start Date]. Despite these efforts, there has been no significant improvement in the cranial symmetry, and the deformity remains in the [Moderate/Severe] range.

Treatment Plan:
The patient is currently within the optimal age range for treatment ([Age in months]). A custom-molded cranial orthosis is required to direct growth into the flattened areas of the skull. This treatment is necessary to prevent permanent craniofacial deformity and potential future complications related to jaw alignment or visual field discrepancies.

In view of the above, I request immediate approval for this medically necessary treatment.

Sincerely,

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