Date: [Insert Date]
To: [Insurance Company Name]
Attention: Utilization Management / Medical Review Department
Fax: [Insert Fax Number]

RE: Letter of Medical Necessity for Cranial Remolding Orthosis
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Policy Number: [Insert Policy Number]
Group Number: [Insert Group Number]
ICD-10 Code(s): [e.g., Q67.3 Plagiocephaly / Q67.2 Dolichocephaly]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to document the medical necessity for a custom Cranial Remolding Orthosis (HCPCS Code: S1040). [Patient Name] is currently [Number] months of age and has been diagnosed with [Specific Diagnosis, e.g., Deformational Plagiocephaly].

Clinical Findings:
Physical examination of the patient's cranium reveals the following measurements:
- Cranial Vault Asymmetry (CVA): [Insert Measurement] mm
- Cephalic Index (CI): [Insert Percentage] %
- Evidence of: [e.g., ear shift, forehead bossing, facial asymmetry]

Treatment History:
Prior to this recommendation, the patient has undergone conservative treatment including:
- [X] weeks/months of supervised neck exercises and "tummy time."
- [X] weeks/months of aggressive repositioning therapy.
Despite these interventions, the cranial deformity persists and exceeds the threshold for moderate-to-severe impairment.

Medical Necessity:
The requested Cranial Remolding Orthosis is medically necessary to correct the significant cranial asymmetry and prevent potential future complications, including jaw misalignment and permanent facial asymmetry. The patient has the necessary head control and is within the appropriate age window (3-18 months) for optimal correction.

I request approval for this orthotic device to begin treatment immediately. Please contact my office at [Phone Number] if further clinical documentation is required.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]

[Clinic Name]
[NPI Number]