Date: [Date]

TO: [Insurance Company Name]
ATTN: Claims/Appeals Department
FAX: [Insurance Fax Number]

RE: Letter of Medical Necessity for Cranial Remolding Orthosis
Patient Name: [Patient First and Last Name]
Date of Birth: [Patient DOB]
Policy ID Number: [Policy ID]
Group Number: [Group Number]
Diagnosis Code (ICD-10): Q67.3 (Plagiocephaly)

To Whom It May Concern,

I am writing to formally request authorization and coverage for a Cranial Remolding Orthosis (S0108) for the above-mentioned patient. This patient has been diagnosed with severe non-synostotic plagiocephaly.

Clinical Findings:
The patient is currently [Number] months of age. Clinical examination and anthropometric measurements indicate a significant cranial asymmetry. The following measurements were recorded on [Date]:

- Cranial Diagonal Difference (Asymmetry): [Number] mm
- Cephalic Index: [Number] %
- Severity Scale: Severe

Previous Conservative Treatment:
Conservative measures, including supervised "tummy time" and aggressive neck repositioning, were implemented for a period of [Number] weeks. Despite these efforts, there has been no significant improvement in the cranial symmetry, and the deformity remains in the severe range.

Medical Necessity:
The patient has reached an age where skull plates are beginning to fuse, making the use of a cranial remolding orthosis time-sensitive. Left untreated, severe plagiocephaly can lead to permanent facial asymmetry, jaw misalignment (TMJ issues), and difficulties with protective headgear (helmets) or eyewear in the future. This orthosis is not for cosmetic purposes but is a corrective medical intervention to restore functional cranial proportions.

Recommendation:
Based on the clinical severity and the failure of conservative repositioning therapy, I am prescribing the use of a custom-molded Cranial Remolding Orthosis to be worn 23 hours a day for a duration of [Number] months.

Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical Practice Name]
[NPI Number]