Date: [Date]

To: [Insurance Company Name]
Attention: Medical Review/Appeals Department
Patient Name: [Patient Full Name]
Patient DOB: [Date of Birth]
Policy Number: [Policy ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number if applicable]

Subject: Letter of Medical Necessity for Cranial Remolding Orthosis (CPT S1040)

To Whom It May Concern,

I am writing to provide formal documentation of medical necessity for a Cranial Remolding Orthosis (Helmet) for my patient, [Patient Name].

Clinical Diagnosis:
[Patient Name] was diagnosed with [Type of Craniosynostosis, e.g., Sagittal, Coronal, or Metopic Craniosynostosis]. Due to the premature fusion of the cranial sutures, the patient underwent [Type of Surgery, e.g., Endoscopic Strip Craniectomy or Cranial Vault Remodeling] on [Date of Surgery].

Medical Necessity:
Following surgical intervention for craniosynostosis, the use of a custom-molded cranial orthosis is a vital component of the post-operative treatment plan. The orthosis is required to:

- Direct and manage cranial growth following the release of the fused suture.
- Protect the surgical site during the healing phase.
- Correct residual skull deformity and prevent the recurrence of abnormal head shape.
- Maintain the structural integrity of the skull while allowing for rapid brain expansion.

Clinical Findings:
Post-operative measurements indicate [Insert specific measurements/Cephalic Index if available]. Without the use of this orthotic device, there is a significant risk of suboptimal surgical outcome, permanent craniofacial asymmetry, and potential restriction of brain growth.

Requested Device:
I am prescribing a custom-fabricated Cranial Remolding Orthosis (HCPCS Code: S1040). The patient will require follow-up adjustments and monitoring throughout the duration of the treatment, estimated to be [Length of time, e.g., 4-6 months].

In summary, this orthosis is not cosmetic; it is a medically necessary follow-up treatment to a reconstructive surgical procedure. I request that you approve coverage for this device.

If you require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical Specialty]
[NPI Number]
[Clinic/Hospital Name]