[Date]
[Insurance Company Name]
[Attn: Appeals/Authorization Department]
[Insurance Address]
[City, State, Zip]

RE: Letter of Medical Necessity for Cranial Remolding Orthosis
Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group Number]
ICD-10 Code: [e.g., Q67.3 Plagiocephaly]

To Whom It May Concern,

I am writing to formally request coverage for a custom cranial remolding orthosis (HCPCS S1040) for my patient, [Patient Name].

[Patient Name] is [Age] old and presents with significant asymmetrical cranial deformation. Clinical examination and anthropometric measurements confirm a diagnosis of [Plagiocephaly/Brachycephaly/Scaphocephaly]. The objective measurements are as follows:

- **Cranial Vault Asymmetry (CVA):** [Measurement] mm
- **Cephalic Index:** [Percentage]%
- **Ear Deviation/Frontal Bossing:** [Present/Absent]

The patient has undergone a [Number]-week trial of conservative treatment, including supervised tummy time and repositioning techniques. Despite these efforts, the cranial asymmetry remains in the [Moderate/Severe] range and shows no significant improvement.

At this stage of development, the cranial sutures remain open, but the window for corrective growth is closing. A custom cranial orthosis is medically necessary to guide symmetrical skull growth and prevent permanent facial and cranial deformity. Failure to treat this condition may lead to long-term complications, including mandibular asymmetry, visual field defects, and auditory canal misalignment.

I recommend the immediate initiation of cranial remolding therapy. Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

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