Date: [Date]
To: [Insurance Company Name]
Attention: Medical Review/Appeals Department
Fax/Address: [Fax Number or Address]

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Policy Number: [Policy ID Number]
Group Number: [Group Number]
Case Reference Number: [Reference Number if applicable]

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

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to formally request authorization and coverage for a custom Cranial Remolding Orthosis (CRO). [Patient Name] is currently under my neurological care for the treatment of a significant cranial deformity.

Diagnosis:
[Select applicable: Plagiocephaly (ICD-10 Q67.3) / Brachycephaly (ICD-10 Q67.2) / Scaphocephaly (ICD-10 Q67.4)]

Clinical Findings:
Following a comprehensive neurological and physical evaluation on [Date of Exam], the following anthropometric measurements were recorded:
- Cephalic Index: [Value]%
- Cranial Vault Asymmetry (CVA): [Value] mm
- [Optional: Other relevant measurements]

Treatment History:
Prior to this recommendation, the patient has undergone conservative management, including:
- [Duration] of supervised "tummy time" and repositioning therapy.
- [Duration] of Physical Therapy for associated Torticollis (if applicable).
Despite these interventions, the cranial asymmetry remains in the [Moderate/Severe] range and has not shown sufficient spontaneous improvement.

Medical Necessity:
The requested Cranial Remolding Orthosis is medically necessary to prevent further permanent deformity and potential secondary clinical complications, including jaw misalignment (TMJ), visual field discrepancies, and significant auditory canal shifts. Due to the closure of the cranial sutures, the window for effective corrective treatment is time-sensitive.

Recommendation:
Based on the patient's age and the severity of the deformity, I am prescribing a custom-molded

Cranial Remolding Orthosis (HCPCS S1040) to be worn 23 hours per day for a period of [Expected Duration] months.

I request that you approve this essential medical device for the treatment of [Patient Name]'s condition. Please contact my office at [Phone Number] if you require additional clinical documentation.

Sincerely,

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