Date: [Insert Date]

TO: [Insurance Company Name]
ATTN: Appeals/Medical Review Department
FAX/ADDRESS: [Insert Fax Number or Address]

RE: Letter of Medical Necessity for Cranial Remolding Orthosis
Patient Name: [Patient Name]
Date of Birth: [Patient DOB]
Policy Number: [Policy ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Insert Number if applicable]

To Whom It May Concern,

I am writing to provide formal documentation of medical necessity for a Cranial Remolding Orthosis (HCPCS S1040) for the above-referenced patient. [Patient Name] has been diagnosed with [Insert Diagnosis: e.g., Deformational Plagiocephaly (ICD-10 Q67.3) or Brachycephaly (ICD-10 Q67.2)].

Clinical History and Findings:
The patient is [Insert Age] months old. Initial clinical assessments conducted on [Insert Date] revealed a significant cranial asymmetry. The objective measurements are as follows:

- Cranial Vault Asymmetry (CVA): [Insert mm]
- Cephalic Index (CI): [Insert %]

Failure of Conservative Repositioning Therapy:
In accordance with clinical guidelines, a supervised program of conservative repositioning therapy was implemented starting on [Start Date] and continued through [End Date/Present]. This program included:

- Aggressive "tummy time" while awake and supervised.
- Alternating head position during sleep.
- Decreasing time spent in car seats, swings, or bouncers.
- Physical therapy exercises for associated torticollis (if applicable).

Despite these consistent efforts over a period of [Number] months, the patient's cranial deformity has failed to show significant clinical improvement. Follow-up measurements taken on [Date] indicate that the asymmetry remains in the [Moderate/Severe] range and is beyond the threshold where natural correction or repositioning is effective due to the patient's age and developmental stage.

Medical Necessity:
The Cranial Remolding Orthosis is medically necessary at this time to prevent further worsening

of the deformity and to correct existing asymmetry while the cranial sutures remain open. Failure to treat this condition may result in permanent craniofacial abnormalities.

I request that you approve coverage for this essential medical device. Please contact my office at [Phone Number] if you require additional clinical records.

Sincerely,

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