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

RE: Letter of Medical Necessity for Cranial Remolding Orthosis
Patient Name: [Patient First and Last Name]
Date of Birth: [Patient DOB]
Policy Number: [Insurance Policy Number]
Group Number: [Group Number]
Diagnosis Code(s): [e.g., Q67.3 Plagiocephaly / Q67.2 Dolichocephaly]

To Whom It May Concern,

I am writing to formally request coverage for a Cranial Remolding Orthosis (HCPCS Code: S1040) for the above-referenced patient. [Patient Name] is currently under my care for the treatment of significant cranial asymmetry.

Clinical History and Diagnosis:
The patient is [Age] months old and presents with [Diagnosis, e.g., Deformational Plagiocephaly]. This condition was first noted at [Age] months. Despite a [Number] week trial of conservative treatment, including supervised tummy time and repositioning techniques, the cranial deformity has failed to improve and remains in the [Moderate/Severe] range.

Anthropometric Measurements:
Clinical measurements obtained on [Date] confirm the severity of the condition:
- Cephalic Index: [Percentage]%
- Cranial Vault Asymmetry (CVA): [Measurement in mm] mm
- [Other relevant measurements, e.g., Ear Shift or Orbit Asymmetry]

Medical Necessity:
A Cranial Remolding Orthosis is medically necessary for this patient to prevent further permanent facial and cranial distortion. If left untreated, this condition may lead to [mention risks: e.g., permanent jaw misalignment, visual field defects, or significant psychological distress due to physical deformity].

The optimal window for treatment is between 4 and 12 months of age while the cranial sutures remain open and the brain is rapidly expanding. Therefore, I recommend the immediate initiation of helmet therapy for 23 hours per day for a duration of [Number] months.

Thank you for your prompt attention to this matter. Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

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