[Physician Clinic/Hospital Letterhead]

Date: [Date]

To: [Insurance Company Name]
Attn: [Claims/Pre-authorization Department]
Fax/Address: [Fax Number or Address]

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

Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy Number: [ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to request authorization for a Cranial Remolding Orthosis (CRO) for the above-referenced patient, who has been diagnosed with Scaphocephaly (ICD-10: Q67.2).

Clinical Findings:
The patient is [Age] months old. Evaluation reveals a significant elongation of the skull (dolichocephaly) consistent with scaphocephaly. Anthropometric measurements indicate a Cephalic Index (CI) of [CI Percentage]%, which is significantly below the normal range (Standard: 75%-85%).

Conservative Treatment History:
Repositioning therapy and neck stretching exercises were attempted for a period of [Number] weeks. Despite these efforts, the cranial deformity has not improved and remains in the [Moderate/Severe] range.

Medical Necessity:
Scaphocephaly, if left untreated, can lead to permanent craniofacial deformity. The patient's sutures are currently open, and this is the critical window for orthotic intervention to direct cranial growth toward a physiological shape. This device is not being requested for cosmetic reasons, but to correct a documented structural deformity and prevent future complications.

Recommendation:
Based on the severity of the Cephalic Index and the failure of conservative management, I am prescribing a custom-molded Cranial Remolding Orthosis. This treatment is the standard of care for a deformity of this magnitude.

Please contact my office at [Phone Number] if further documentation is required.

Sincerely,

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