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

RE: Letter of Medical Necessity for Cranial Remolding Orthosis

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Policy Number: [Policy Number]
Group Number: [Group Number]
Claim Number: [Claim Number (if applicable)]

Dear Medical Director,

I am writing this letter to document the medical necessity for a Cranial Remolding Orthosis (HCPCS code: S1040) for the above-referenced patient. [Patient Name] has been diagnosed with [Diagnosis, e.g., Deformational Plagiocephaly/Brachycephaly] (ICD-10: [ICD-10 Code]).

Clinical Findings:
The patient was evaluated on [Date]. Clinical assessment and anthropometric measurements indicate a significant cranial deformity. Current measurements are as follows:
- Cephalic Index: [Value]%
- Cranial Vault Asymmetry (CVA): [Value] mm
- Severity Level: [e.g., Moderate to Severe]

Conservative Treatment History:
Prior to this recommendation, the following conservative measures were attempted for a period of [Number] weeks:
- Repositioning therapy
- Tummy time exercises
- Physical therapy for Torticollis (if applicable)
The deformity has failed to improve with these measures, and the patient's cranial sutures remain open, providing a window for orthotic correction.

Medical Justification:
A custom-molded cranial orthosis is required to apply direct pressure to the prominent areas of the cranium while allowing room for growth in the flattened regions. Failure to treat this condition at this developmental stage may result in permanent facial asymmetry, ocular abnormalities, and mandibular misalignment.

I am requesting authorization for the fabrication and fitting of this orthosis to prevent further progression and correct the existing deformity. Please contact our office at [Phone Number] if you require additional clinical documentation.

Sincerely,

[Doctor/Orthotist Name]
[Title/Credentials]
[Facility Name]
[NPI Number]