Date: [Insert Date]

TO: [Insurance Company Name]
ATTN: [Claims/Appeals Department]
ADDRESS: [Insurance Company Address]

RE: Letter of Medical Necessity for Speech Generating Device
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Policy Number: [Insurance ID Number]
Group Number: [Group Number]
ICD-10 Code: [e.g., G80.9 Cerebral Palsy, R48.8 Other symbolic dysfunctions]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to formally request coverage for a touch-based Speech Generating Device (SGD), specifically the [Insert Device Model Name]. [Patient Name] has a diagnosis of Cerebral Palsy, which significantly impairs their motor speech production and expressive communication abilities.

Clinical Status and Diagnosis:
The patient presents with [Insert specific type, e.g., Spastic Quadriplegic] Cerebral Palsy. This condition has resulted in severe dysarthria and non-verbal status. Currently, the patient's natural speech is insufficient to meet their daily functional communication needs for health, safety, and basic interaction.

Evaluation Results:
A formal Augmentative and Alternative Communication (AAC) evaluation was conducted on [Date]. During the evaluation, various modalities were trialed. It was determined that a touch-based interface is the most effective access method for [Patient Name] due to [Insert reason, e.g., specific hand-eye coordination levels or limited breath support for speech].

Medical Necessity:
The requested device is a medical necessity for this patient because:

- It allows the patient to communicate physiological needs, pain levels, and medical concerns to caregivers and healthcare providers.
- It serves as the primary tool for the patient to achieve functional communication that cannot be achieved through natural speech or lower-tech methods.
- The patient has demonstrated the cognitive and physical ability to navigate a touch-screen interface to select icons/words.

Treatment Plan:
Upon receipt of the device, [Patient Name] will continue Speech-Language Pathology sessions [Insert frequency, e.g., twice weekly] to focus on linguistic programming, device navigation, and functional integration of the SGD into daily life.

Recommendation:
Based on the clinical assessment, it is my professional opinion that the [Device Name] is the least costly yet most effective equipment to treat this patient's communication disorder. Without this assistive technology, the patient remains unable to communicate basic medical and safety needs.

Please contact me at [Phone Number] if further documentation or information is required.

Sincerely,

[Physician/SLP Signature]
[Printed Name and Credentials]
[NPI Number]
[Facility Name]