Date: [Insert Date]

To: [Insurance Company Name]
Attn: Appeals/Medical Review Department
Address: [Insurance Company Address]

RE: Letter of Medical Necessity for Cognitive Assistive Communication Device
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Policy Number: [Policy ID Number]
Claim/Reference Number: [Insert Number if applicable]

Dear Medical Reviewer,

I am writing to formally request coverage for a [Brand/Model of Device or Software] for my patient, [Patient Name], who sustained a Traumatic Brain Injury (TBI) on [Date of Injury]. I have been treating this patient since [Date] for deficits in communication and cognitive function.

Clinical Diagnosis:
[Insert ICD-10 Codes, e.g., S06.X Traumatic Brain Injury, R41.84 Cognitive Communication Deficit]

Current Clinical Status:
The patient presents with significant impairments in [List specific deficits, e.g., short-term memory, executive functioning, expressive language, or attention]. Due to the severity of these cognitive impairments following the TBI, the patient is unable to independently perform activities of daily living (ADLs) or communicate effectively without assistive technology.

Required Equipment:
The recommended device is a [Name of Device], which includes [Specific Features, e.g., voice-output, schedule reminders, cognitive retraining software].

Medical Necessity:
This device is medically necessary to:
1. Enable the patient to communicate basic needs and medical concerns.
2. Compensate for severe memory loss through digital prompts and sequencing tools.
3. Provide a functional means of interaction to prevent social isolation and secondary psychological decline.
4. Support the patient's safety by managing medication schedules and emergency contacts.

Functional Goals:
With the use of this cognitive assistive device, the patient is expected to [List goals, e.g., increase independence in daily routine by 50%, successfully communicate pain levels to caregivers, or adhere to medication protocols].

Trial Results:
A trial was conducted on [Date] where the patient demonstrated the ability to navigate the device interface and showed immediate improvement in [Specific Task].

In summary, the [Device Name] is an essential component of this patient's rehabilitative plan. Please contact me at [Phone Number] if you require further clinical documentation.

Sincerely,

[Your Signature]
[Your Printed Name and Title]
[Facility Name]
[NPI Number]