

[Date]

[Insurance Company Name]
[Prior Authorization Department]
[Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Assistive Communication Device

Patient Name: [Patient Name]

Date of Birth: [DOB]

Policy Number: [Policy #]

Group Number: [Group #]

Claim/Reference Number: [Reference # if applicable]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to request prior authorization and coverage for a Speech Generating Device (SGD), specifically the [Model Name/Brand].

Clinical Diagnosis and Medical History:

The patient has been diagnosed with [Primary Diagnosis, e.g., Non-verbal Autism, ALS, Cerebral Palsy] (ICD-10 Code: [Code]). As a result of this condition, the patient suffers from severe expressive communication impairment that limits their ability to meet daily functional communication needs.

Speech and Language Evaluation:

A formal evaluation conducted on [Date] by [Speech-Language Pathologist Name] confirms that the patient's natural speech is non-functional for daily communication. The patient has a baseline communication level of [Description of current ability].

Necessity of the Device:

The requested [Model Name] is medically necessary because it will allow the patient to:

- Communicate medical needs and pain levels to caregivers.
- Interact with healthcare providers and participate in treatment decisions.
- Express basic needs for safety and survival.

Trials and Alternatives:

We have explored less costly alternatives, including [List other methods like picture boards or basic apps], but these have proven insufficient because [Reason]. During a trial period with the requested device, the patient demonstrated the ability to [Specific success, e.g., navigate folders, select icons] with [Percentage] accuracy.

Recommendation:

Based on the clinical evidence, the [Model Name] is the most appropriate and least costly medical equipment that meets the patient's functional communication requirements. This device

is not being used for educational or vocational purposes, but as a prosthetic for the patient's voice.

Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Signature]

[Physician/SLP Name and Title]

[NPI Number]

[Clinic/Facility Name]