

**Date:** [Date]

**To:** [Insurance Company Name]

**Attention:** Medical Review/Appeals Department

**Address:** [Insurance Company Address]

**RE: Letter of Medical Necessity for Electrolarynx**

**Patient Name:** [Patient Full Name]

**Policy Number:** [Insurance ID Number]

**Group Number:** [Group Number]

**Date of Birth:** [Patient DOB]

To Whom It May Concern,

I am writing to formally request coverage for an electrolarynx (HCPCS code E2506) for the above-referenced patient. This device is medically necessary for the patient to communicate following a total laryngectomy.

**Clinical Documentation:**

- **Diagnosis:** [Diagnosis Code, e.g., C32.9 Malignant neoplasm of larynx]
- **Surgical Procedure:** Total Laryngectomy performed on [Date of Surgery].
- **Clinical Status:** Due to the surgical removal of the larynx, the patient is aphonic (has no natural voice) and cannot produce functional speech.

**Medical Necessity:**

The patient requires an electrolarynx as a primary method of communication to perform essential activities of daily living and to communicate medical needs. Without this assistive communication device, the patient is unable to express urgent symptoms, interact with healthcare providers, or maintain safety in emergency situations. Other forms of non-electronic communication (e.g., writing or gestures) are insufficient for the patient's functional and safety requirements.

**Requested Equipment:**

- **Device:** Electrolarynx (Artificial Larynx)
- **HCPCS Code:** E2506

I certify that the requested equipment is medically necessary for this patient's treatment and rehabilitation. Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

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