

[Date]
[Insurance Company Name]
[Claims/Appeals Department Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Replacement Speech Generating Device

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
ICD-10 Diagnosis Code(s): [e.g., F84.0, R47.01]

To Whom It May Concern,

I am writing to formally request the replacement of a Speech Generating Device (SGD) for my patient, [Patient Name]. [Patient Name] has been diagnosed with [Primary Diagnosis] resulting in a severe expressive communication impairment that prevents them from meeting daily functional communication needs through natural speech.

Current Device Status:

The patient is currently using a [Brand/Model of Current Device] which was issued on [Date of Original Purchase]. This device is now [Number] years old and is considered outdated for the following reasons:

- The hardware is failing and no longer supports necessary software updates.
- The manufacturer has designated the device as "End of Life," meaning replacement parts and technical support are no longer available.
- The processing speed is insufficient for the patient's current communication rate, causing significant delays and frustration.
- [Optional: Mention battery failure or physical damage that is non-repairable].

Proposed Replacement:

Based on a recent clinical evaluation, I am recommending the [Name of New Device/Software]. This device is a piece of Durable Medical Equipment (DME) categorized as a dedicated Speech Generating Device (HCPCS Code [e.g., E2510]).

Clinical Justification:

The requested device is medically necessary to allow [Patient Name] to communicate medical needs, pain levels, and safety concerns. Without a functional, up-to-date SGD, the patient is unable to interact with healthcare providers or caregivers effectively. The new device offers [Specific Feature, e.g., eye-tracking, improved battery life, or advanced linguistic software] which is essential for the patient's current functional level.

Statement of Necessity:

This replacement is not for convenience or educational purposes, but is a medical necessity to

treat the patient's communication disorder. It is the most cost-effective solution to ensure the patient maintains a functional means of communication.

Thank you for your prompt consideration of this request. Please contact me at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician/SLP Signature]

[Printed Name and Credentials]

[NPI Number]

[Facility/Clinic Name]