[Physician Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]

**Date:** [Current Date]

**To:** [Insurance Company Name]
**Attn:** [Appeals/Authorization Department]
**Fax/Address:** [Fax Number or Address]

**RE: Letter of Medical Necessity Submission**

**Patient Name:** [Patient Name]
**Date of Birth:** [DOB]
**Policy Number:** [Policy ID]
**Group Number:** [Group Number]
**Claim/Reference Number:** [Reference Number, if applicable]

To Whom It May Concern,

Please find the attached Letter of Medical Necessity and supporting clinical documentation for the patient listed above. This request is for the approval of [Name of Treatment, Medication, or Equipment].

As of [Date of Submission], this documentation confirms that the requested service is essential for the treatment of the patient's diagnosis: [Diagnosis Code/Name]. Failure to provide this treatment may result in [Brief mention of potential health risks].

Please update the patient's file to reflect the submission date of this documentation. We look forward to your timely review and determination.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[NPI Number]