

PHYSICIAN DECLARATION OF MEDICAL NECESSITY

Date: [Date]

Patient Name: [Patient Name]

Date of Birth: [DOB]

Policy Number: [Policy Number]

Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally declare the medical necessity of [Name of Treatment/Procedure/Medication/Equipment] for the above-mentioned patient. I have been the treating physician for [Patient Name] since [Date].

Clinical Diagnosis:

The patient has been diagnosed with [Diagnosis Name] (ICD-10 Code: [Code]).

Clinical Justification:

[Patient Name] presents with the following symptoms and clinical history: [Briefly describe symptoms and previous treatments failed]. Based on the patient's current clinical status, the requested [Treatment/Service] is essential for the following reasons:

- [Reason 1]
- [Reason 2]

Declaration:

In my professional medical opinion, this treatment is not elective. It is standard of care for this diagnosis and is necessary to [prevent further clinical deterioration / improve functional status / manage chronic pain]. Failure to provide this service may result in [adverse health outcomes].

I request that you approve coverage for this medically necessary intervention.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Medical Specialty]

[NPI Number]

[Phone Number]

[Clinic/Hospital Name]