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

RE: Letter of Medical Necessity for Biofeedback Therapy
Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Policy Number: [Policy Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request coverage for biofeedback therapy (CPT Code 90901) for my patient, [Patient Name], who is currently under my care for the treatment of chronic migraine headaches (ICD-10 Code G43.x).

Clinical History:
The patient has been diagnosed with migraine headaches for [Duration of Time]. Currently, the patient experiences [Number] headache days per month. These episodes are characterized by [Description of severity/symptoms] and significantly impair the patient's ability to perform activities of daily living and maintain employment.

Previous Treatments:
To date, the patient has attempted the following pharmacological and conservative treatments with inadequate results or intolerable side effects:
- [List Medication 1]
- [List Medication 2]
- [Other treatments like Physical Therapy/Injections]

Medical Necessity:
Biofeedback therapy is medically necessary for this patient to reduce the frequency and intensity of migraine attacks and to decrease dependence on acute abortive medications, which carry risks of medication overuse headache and systemic side effects. Clinical evidence supports biofeedback as an effective, non-invasive intervention for migraine management by teaching the patient to regulate physiological responses to stress and pain triggers.

Treatment Plan:
The recommended treatment plan consists of [Number] sessions of biofeedback therapy over a period of [Number] weeks. Progress will be monitored via headache diaries and functional assessment scales.

I request that you approve coverage for these services to ensure the patient receives the necessary standard of care for their condition. Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Practice Name]