Date: [Insert Date]

To: [Insurance Company Name]
Attention: [Claims/Appeals Department]
Address: [Insurance Company Address]
City, State, Zip: [City, State, Zip]

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

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to document the medical necessity of Biofeedback Therapy (CPT Code: 90901/90875) as a primary or adjunctive treatment for Attention Deficit Hyperactivity Disorder (ADHD).

Clinical Diagnosis:
[Patient Name] has been diagnosed with [Specific ADHD Subtype, e.g., Combined Presentation] (ICD-10 Code: [Insert Code, e.g., F90.2]). The patient exhibits significant symptoms including [list symptoms, e.g., impulsivity, inability to sustain focus, emotional dysregulation, and executive function deficits]. These symptoms significantly impair the patient's performance in [school/work/daily living].

Previous Treatments:
The patient has attempted the following treatments with insufficient results:
- [Pharmacological treatment and outcome]
- [Behavioral therapy and outcome]
- [Other interventions]

Rationale for Biofeedback Therapy:
Biofeedback is a non-invasive, evidence-based intervention that allows the patient to gain voluntary control over physiological responses. For this patient, Biofeedback is medically necessary to:
1. Improve self-regulation of physiological arousal levels associated with ADHD.
2. Enhance cognitive focus and attention span without the side effects associated with stimulant medication.
3. Reduce impulsive behaviors through real-time neurological feedback.

Treatment Plan:
The recommended treatment plan consists of [Number] sessions, occurring [Frequency, e.g., twice weekly]. We will monitor progress via [specific assessment tools] to ensure the patient is meeting clinical milestones.

In summary, Biofeedback Therapy is an essential component of [Patient Name]'s treatment plan. I request that you approve coverage for these services to prevent further functional decline and support the patient's long-term health outcomes.

Please contact me at [Phone Number] or [Email Address] if you require additional clinical documentation.

Sincerely,

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