Date: [Date]

TO: [Insurance Company Name]
ATTN: Medical Review/Appeals Department
ADDRESS: [Insurance Company Address]

RE: Letter of Medical Necessity for Biofeedback Therapy

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

To Whom It May Concern,

I am writing to formally request coverage for Biofeedback Therapy (CPT Code: 90901) for the above-named patient. This treatment is medically necessary to manage and modulate **Essential Hypertension (ICD-10 Code: I10)**.

Clinical History:
The patient has been diagnosed with essential hypertension since [Date of Diagnosis]. Current clinical readings indicate persistent elevated blood pressure levels despite standard interventions. Specifically, the patient's average readings are [Insert BP Readings].

Previous Treatments:
The patient has attempted the following treatments with inadequate results or adverse side effects:
- [Medication Name/Dose]: [Results/Side Effects]
- [Lifestyle Modifications]: [Results]
- [Other Therapies]: [Results]

Medical Justification:
Biofeedback therapy is indicated for this patient to provide physiological self-regulation of the autonomic nervous system. Clinical evidence supports biofeedback as an effective non-pharmacological intervention for lowering systolic and diastolic blood pressure. In this case, biofeedback will be used to reduce sympathetic arousal and enhance vascular relaxation, directly addressing the underlying mechanisms of the patient's hypertension.

Treatment Plan:
The recommended course of treatment involves [Number] sessions of biofeedback therapy. The goal of this therapy is to achieve a sustained reduction in blood pressure, reduce reliance on [Medication Name], and mitigate the risk of cardiovascular complications such as stroke or myocardial infarction.

I request that you approve this request for Biofeedback Therapy to ensure the patient receives the necessary standard of care for their condition. If you require additional documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

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