[Date]

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

RE: Letter of Medical Necessity for Biofeedback Therapy
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Policy Number: [Policy ID]
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 management of Raynaud's Disease (ICD-10 Code: I73.00).

Clinical History:
The patient suffers from severe vasospastic attacks triggered by cold temperatures and emotional stress. Symptoms include significant pain, numbness, skin color changes, and [mention any other symptoms like digital ulcers or loss of function].

Previous Treatments:
The patient has attempted the following conservative treatments with inadequate results:

- [List medications, e.g., Calcium Channel Blockers]
- [List lifestyle modifications, e.g., thermal protection]
- [List other attempted interventions]

Medical Necessity for Biofeedback:
Biofeedback therapy is medically necessary for this patient to gain voluntary control over peripheral skin temperature and vasomotor responses. Clinical evidence supports biofeedback as an effective, non-pharmacological intervention for Raynaud's Disease to reduce the frequency and severity of painful vasospasms and prevent potential tissue damage.

Treatment Plan:
I am prescribing [Number] sessions of Thermal Biofeedback Training. The goal is to improve digital blood flow and increase the patient's threshold for cold-induced attacks.

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

Sincerely,

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