Date: [Date]

To: [Insurance Company Name / School District / Employer]
From: [Physician Name], [Credentials]
Subject: Letter of Medical Necessity for [Patient Name]

To Whom It May Concern:

I am writing on behalf of my patient, [Patient Name], Date of Birth: [DOB], who is under my care for the treatment of Celiac Disease (ICD-10 Code: K90.0).

Celiac Disease is a chronic, autoimmune disorder where the ingestion of gluten leads to damage in the small intestine. At this time, the only medically recognized treatment for this condition is a strict, life-long gluten-free diet. Ingestion of even trace amounts of gluten can cause severe physical symptoms and long-term health complications, including malnutrition, bone disease, and increased risk of malignancy.

Due to this medical diagnosis, it is medically necessary for [Patient Name] to have the following modifications:

- Strict avoidance of all foods containing wheat, barley, rye, and their derivatives.
- Access to gluten-free meal substitutions that meet nutritional requirements.
- Prevention of cross-contamination in food preparation areas and during service.
- [Optional: Specific mention of specialized medical foods or gluten-free supplements].

Please ensure that these dietary accommodations are provided to prevent acute illness and long-term medical complications. If you require further information regarding this patient's medical status, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]
[Clinic/Hospital Name]