Date: [Insert Date]

TO: [Insurance Company Name / Recipient Name]
ATTN: [Department Name, e.g., Claims/Appeals]
FAX/ADDRESS: [Insert Fax Number or Address]

RE: Letter of Medical Necessity for Diabetic Nutrition Diet Modifications
Patient Name: [Insert Patient Name]
Date of Birth: [Insert DOB]
Member ID: [Insert ID Number]
Group Number: [Insert Group Number]

To Whom It May Concern,

I am writing to formally request coverage for [Specific Service, e.g., Medical Nutrition Therapy, Specialized Diabetic Meal Plans, or Consultation] for my patient, [Patient Name].

Clinical Diagnosis:
The patient has been diagnosed with [Insert Diagnosis, e.g., Type 2 Diabetes Mellitus, ICD-10 Code: E11.9]. Currently, the patient's clinical status is as follows: [Insert HbA1c levels, fasting glucose, or recent complications].

Medical Necessity:
Due to the patient's diagnosis, strict adherence to a specific diabetic nutrition plan is medically necessary to manage blood glucose levels, prevent hypoglycemia/hyperglycemia, and reduce the risk of long-term complications such as neuropathy, retinopathy, and renal failure.

Prescribed Intervention:
I have prescribed a specialized diet consisting of [Insert details, e.g., consistent carbohydrate counting, low glycemic index requirements, or specific caloric intake]. [Patient Name] requires [Number of sessions or duration] of Medical Nutrition Therapy to ensure successful implementation and stabilization of their condition.

In my professional medical opinion, these nutritional modifications and services are essential to the patient's health and are not elective or cosmetic in nature.

Please contact my office at [Phone Number] if you require additional medical records or documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO/NP/PA]
NPI Number: [Insert NPI]
Practice Name: [Insert Practice Name]