Date: [Date]

To: [Insurance Company Name]
Attention: [Prior Authorization/Medical Review Department]
Fax/Address: [Fax Number or Address]

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]

Subject: Letter of Medical Necessity for Enteral Formula and Diet Modifications

To Whom It May Concern,

I am writing to request coverage for enteral nutrition formula and specific diet modifications for my patient, [Patient Name]. I have been treating this patient since [Date] for the following medical conditions:

- [Diagnosis Name and ICD-10 Code]
- [Diagnosis Name and ICD-10 Code]

Clinical Justification:
The patient requires enteral formula because they are unable to meet their nutritional requirements through a standard diet due to [Reason: e.g., malabsorption, severe dysphagia, metabolic disorder, failure to thrive]. Specifically, the patient exhibits [Symptoms: e.g., chronic vomiting, weight loss, inability to swallow safely].

Required Product/Formula:
I am prescribing [Specific Name of Formula/Product]. This formula is medically necessary because it is [Reason: e.g., elemental, peptide-based, calorie-dense] and is required to manage the patient's condition.

Prescription Details:

- **Method of Delivery:** [e.g., Oral or Tube Fed (NG/G-Tube/J-Tube)]
- **Caloric Requirement:** [Number] calories per day
- **Volume:** [Number] ounces/mL per day
- **Duration:** [e.g., 12 months or Lifetime]

Previous Interventions:
The following formulas or nutritional interventions were trialed and failed: [List failed formulas/diets and reasons for failure, e.g., intolerance, allergic reaction].

In summary, [Patient Name] requires this specific enteral formula as a primary component of their medical treatment. Failure to provide this nutritional support may result in [Potential Complications: e.g., hospitalization, surgical intervention, severe malnutrition].

Please contact my office at [Phone Number] if further documentation is required.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO/NP/PA]
[NPI Number]
[Clinic/Hospital Name]