Date: [Date]
To: [Insurance Company Name / Health Organization]
Attention: [Claims/Authorization Department]
Re: Letter of Medical Necessity for Pureed Diet Modifications

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Provider Name: [Physician/SLP Name]

To Whom It May Concern,

I am writing to formally document the medical necessity of a **Pureed Diet (IDDSI Level 4)** and associated nutritional modifications for the above-named patient. [Patient Name] has been diagnosed with **Dysphagia (ICD-10 Code: [Code])** secondary to [Primary Diagnosis, e.g., Stroke, Parkinson's Disease, ALS, or Traumatic Brain Injury].

Based on a recent [Clinical Swallow Evaluation / Videofluoroscopic Swallow Study] performed on [Date], the patient exhibits the following clinical indications:

- Impaired oral-motor control and bolus formation.
- Reduced pharyngeal clearance and delayed swallow reflex.
- Significant risk of aspiration, choking, or silent aspiration with thin liquids or solid food textures.
- [List any other relevant symptoms, e.g., unintentional weight loss or recurrent pneumonia].

As a result of these findings, it is medically necessary for the patient to consume a diet consisting exclusively of pureed foods that are smooth, cohesive, and require no chewing. This modification is essential to:

1. Prevent life-threatening aspiration pneumonia.
2. Ensure safe airway protection during deglutition.
3. Maintain adequate hydration and caloric intake to prevent malnutrition and dehydration.

I am requesting coverage for [Specific Products, e.g., pre-packaged pureed meals, thickening agents, or specialized nutritional supplements] as they are vital to the patient's treatment plan and safety. Failure to provide these medical grade dietary modifications poses a severe risk to the patient's health and may result in emergency hospitalization.

Please contact me at [Phone Number] or [Email Address] if you require additional documentation or clinical records.

Sincerely,

[Signature]

[Printed Name and Credentials]
[NPI Number]
[Facility/Clinic Name]