Date: [Date]

To: [Name of Insurance Company/Recipient]
Attention: [Department/Claims Department]
Address: [Address, City, State, Zip Code]

Re: Letter of Medical Necessity for Dietary Modifications

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Policy/Member ID: [ID Number]
Diagnosis: [e.g., Crohn's Disease (ICD-10 K50.x) or Ulcerative Colitis (ICD-10 K51.x)]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], who is currently under my care for the management of Inflammatory Bowel Disease (IBD). This letter serves as a formal medical necessity statement for specific dietary modifications and nutritional interventions required for the treatment of their condition.

[Patient Name] suffers from [specific condition], a chronic inflammatory condition of the gastrointestinal tract. Due to the severity of their symptoms, which include [list symptoms, e.g., chronic inflammation, malabsorption, strictures, or weight loss], standard diet and over-the-counter food options are insufficient for maintaining health and managing disease activity.

I have prescribed the following medical nutrition therapy: [Insert Specific Diet, e.g., Exclusive Enteral Nutrition (EEN), Specific Carbohydrate Diet (SCD), Low FODMAP, or specific medical foods/supplements].

This dietary intervention is medically necessary for this patient to:

- Reduce intestinal inflammation and promote mucosal healing.
- Prevent malnutrition and correct micronutrient deficiencies.
- Reduce the frequency of disease flares and the need for corticosteroids or surgery.
- Maintain adequate growth and weight (especially relevant for pediatric patients).

In this clinical context, the prescribed dietary modification is not for general health or weight loss, but is a therapeutic requirement for the management of a diagnosed chronic disease. Failure to adhere to this dietary protocol may result in a significant worsening of the patient's condition and increased healthcare costs due to hospitalization or surgical intervention.

Please approve coverage for [the specific dietary items, nutritional counseling, or supplements] as part of this patient's essential medical treatment plan.

Should you require additional information, please contact my office at [Phone Number].

Sincerely,

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