Date: [Date]

To: [Insurance Company Name / School Administrator / Workplace HR]
Attention: [Department Name]
Fax/Address: [Fax Number or Address]

RE: Letter of Medical Necessity for Dietary Modifications

Patient Name: [Patient Name]
Date of Birth: [Patient DOB]
Member ID: [Insurance ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally document the medical necessity of specific dietary modifications for my patient, [Patient Name], who is under my care for the treatment of **Eosinophilic Esophagitis (EoE)**, ICD-10 code K20.0.

EoE is a chronic, immune-mediated clinicopathological disease of the esophagus. In this condition, eosinophils (a type of white blood cell) infiltrate the esophagus, causing inflammation, tissue damage, and potential scarring. This can lead to dysphagia (difficulty swallowing), food impaction, and severe pain.

For this patient, dietary elimination is a primary medical therapy used to achieve and maintain clinical and histological remission. Based on the patient's clinical history and diagnostic testing, I have prescribed the following medically necessary intervention:

- **Specific Elimination Diet:** Strict avoidance of [List specific allergens, e.g., Dairy, Wheat, Eggs, Soy, Peanuts/Tree Nuts, Seafood].
- **Medical Grade Formula:** Use of [Brand Name] amino-acid based elemental formula as a primary or supplemental nutrition source.
- **Equipment/Supplies:** [List any necessary feeding supplies if applicable].

Strict adherence to this diet is not a lifestyle choice but a medical requirement to prevent esophageal strictures, malnutrition, and the need for invasive procedures such as esophageal dilations. Even minor cross-contamination can trigger an inflammatory response.

I request that you provide [coverage/accommodations] for these prescribed medical necessities to ensure the patient's safety and health stabilization.

If you require further clinical documentation or have questions regarding this treatment plan, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Specialty: Gastroenterology/Allergy]
[Practice Name]
[NPI Number]