

Date: [Insert Date]

To: [Recipient Name/Organization]

From: [Physician Name, MD/DO]

Subject: Letter of Medical Necessity for [Patient Name]

Patient Name: [Patient Name]

Date of Birth: [Patient DOB]

Medical Condition: [Insert Diagnosis, e.g., Celiac Disease, Severe Food Allergy]

To Whom It May Concern,

I am the treating physician for [Patient Name]. This letter serves to formally document the medical necessity for specific dietary accommodations required to manage their diagnosed medical condition.

Due to this condition, it is medically necessary for [Patient Name] to strictly adhere to the following dietary requirements:

- **Required Restrictions:** [e.g., Gluten-free, Nut-free, Dairy-free]
- **Necessary Accommodations:** [e.g., Cross-contamination prevention, specific brand requirements, access to supplemental meals]

Failure to comply with these dietary restrictions may result in immediate and severe health complications, including [insert symptoms/risks, e.g., anaphylaxis, gastrointestinal damage, systemic inflammation].

Please ensure that all necessary arrangements are made to accommodate these medical requirements in [Setting, e.g., school, workplace, housing].

If you require further information or clinical documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Medical License Number]

[Clinic/Hospital Name]