[Date]
[Insurance Company Name]
[Claims/Appeals Department Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Continuation of Chronic Pain Management

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Policy ID Number: [Policy Number]
Group Number: [Group Number]
Case Reference Number: [Reference Number, if applicable]

To Whom It May Concern,

I am writing to formally request the continued authorization of chronic pain management services for [Patient Name]. The patient has been under my care for [Duration of Treatment] for the treatment of [Specific Primary Diagnosis/ICD-10 Code] and [Secondary Diagnosis].

Clinical History and Current Status:
The patient suffers from persistent, severe pain located in [Body Part(s)]. This condition significantly impacts the patient's functional status, including [mention specific limitations, e.g., mobility, sleep, or ability to perform daily tasks]. Recent evaluations on [Date of Last Visit] confirm that the patient continues to require structured intervention to manage symptoms and prevent physical decline.

Treatment Plan and Progress:
To date, the patient has responded [positively/stably] to the following treatment plan: [List treatments, e.g., specific medications, physical therapy, or interventional procedures]. Continued care is necessary to maintain the patient's current level of function and to prevent the exacerbation of symptoms that would necessitate more invasive or costly emergency interventions.

Medical Necessity for Continuation:
Discontinuation or interruption of this care would likely result in a significant increase in pain intensity, loss of functional independence, and [mention other risks, e.g., increased reliance on acute care services]. The proposed continuation of [Specific Treatment/Service] is consistent with established medical standards for the management of chronic pain in patients with [Diagnosis].

I request that you approve the request for [Number of Sessions/Duration of Treatment]. If you require additional clinical documentation or have any questions, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name], [Credentials]
[Practice Name]
[NPI Number]