[Physician Name]
[Facility/Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Insurance Company Name]
[Attn: Appeals/Medical Review Department]
[Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Continuation of Oncology Treatment
Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group ID]
Claim/Reference Number: [Reference Number]

To Whom It May Concern:

I am writing to formally request the authorization for the continuation of oncology treatment for [Patient Name]. This patient is currently under my care for the diagnosis of [Specific Cancer Type and Stage], ICD-10 code [Insert Code].

The patient began the current treatment regimen of [Name of Medication/Therapy/Procedure] on [Start Date]. To date, the patient has completed [Number] cycles. Recent clinical evaluations and diagnostic imaging performed on [Date] demonstrate [describe positive response, e.g., tumor shrinkage, stable disease, or decreased biomarkers].

Continuation of this specific treatment plan is medically necessary for the following reasons:

- **Clinical Response:** The patient has shown a documented positive response to the current therapy, and interruption of care poses a significant risk of disease progression.
- **Standard of Care:** This treatment aligns with NCCN guidelines and clinical protocols for [Diagnosis].
- **Lack of Alternatives:** Previous treatments including [List previous therapies] were [unsuccessful/not tolerated]. Switching to an alternative therapy at this stage would be clinically inappropriate.

The proposed plan involves [Number] additional cycles of [Treatment Name] over the next [Time Period]. Failure to continue this treatment would likely result in a decline in the patient's clinical status and a decrease in overall survival probability.

Please find attached supporting documentation, including recent pathology reports, imaging results, and progress notes. Should you require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]