

[Date]

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

RE: Letter of Medical Necessity for Continuation of Private Duty Nursing (PDN)

Patient Name: [Patient First and Last Name]

Date of Birth: [MM/DD/YYYY]

Policy Number: [Insurance ID Number]

Group Number: [Group Number]

Request Type: Extension of Ongoing Services

To Whom It May Concern,

I am writing to formally request the continuation of in-home skilled nursing services for [Patient Name]. [Patient Name] has been under my care since [Date] for the treatment of [Primary Diagnosis] and [Secondary Diagnoses].

Clinical Background:

[Patient Name] is a [Age]-year-old individual who remains medically fragile and requires continuous skilled nursing intervention. The patient's condition is characterized by [list specific clinical needs, e.g., ventilator dependence, tracheostomy care, G-tube feedings, frequent seizures, or medication titration].

Medical Necessity for Continued Care:

In-home nursing care is vital for this patient to prevent life-threatening complications and frequent hospitalizations. Skilled nursing is required [Number of Hours] hours per day, [Number of Days] days per week to perform the following tasks:

- [Task 1: e.g., Maintenance and suctioning of airway]
- [Task 2: e.g., Administration of complex medication regimens]
- [Task 3: e.g., Monitoring for acute respiratory distress]
- [Task 4: e.g., Sterile wound care or specialized feeding]

Conclusion:

The current level of care is the least restrictive environment suitable for the patient's clinical stability. Discontinuation or reduction of these services would result in an immediate risk of [mention specific risks, e.g., respiratory failure or infection], likely leading to an emergency room visit or long-term acute care hospitalization.

I strongly urge you to approve the continuation of these essential services. If you require additional medical records or a detailed plan of care, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]