

Date: [Insert Date]

To: [Insurance Company Name]

Attention: [Department/Contact Person]

Fax/Address: [Insert Fax Number or Address]

RE: Letter of Medical Necessity for Continuation of Dialysis Treatment

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

Policy/Member ID: [Member ID Number]

Group Number: [Group Number]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to request the prior authorization and approval for the continuation of life-sustaining dialysis treatment. [Patient Name] has been diagnosed with [Primary Diagnosis, e.g., End-Stage Renal Disease (ESRD) / Stage 5 Chronic Kidney Disease], ICD-10 code: [Insert Code].

Clinical Documentation:

The patient currently has a Glomerular Filtration Rate (GFR) of [Insert GFR] mL/min. Due to the permanent loss of renal function, the patient requires ongoing renal replacement therapy to manage electrolyte imbalances, fluid overload, and uremic toxins. Without regular dialysis treatments, the patient is at immediate risk for life-threatening complications, including pulmonary edema, cardiac arrhythmia, and metabolic acidosis.

Treatment Plan:

The prescribed treatment plan is as follows:

- **Modality:** [e.g., In-center Hemodialysis / Home Peritoneal Dialysis]
- **Frequency:** [e.g., 3 times per week]
- **Duration:** [e.g., Ongoing / Indefinite]
- **Facility:** [Name of Dialysis Center]

This treatment is medically necessary and is the standard of care for the patient's condition. Interruption of these services would result in acute medical crisis and hospitalization.

Please contact my office at [Phone Number] if you require additional medical records or laboratory results to process this request.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Facility/Practice Name]