[Date]

[Insurance Company Name]
[Insurance Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Continuation of High-Risk Maternity Care

Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy Number: [Policy #]
Group Number: [Group #]
Estimated Date of Delivery: [EDD]

To Whom It May Concern,

I am writing to formally document the medical necessity for [Patient Name] to continue receiving specialized gestational high-risk maternity care under my supervision. The patient is currently at [Number] weeks gestation and presents with complications that require intensive monitoring beyond the scope of routine prenatal care.

Clinical Diagnosis and Justification:
The patient has been diagnosed with the following condition(s):

- [Diagnosis 1 / ICD-10 Code]
- [Diagnosis 2 / ICD-10 Code]
- [History of Preterm Labor / Preeclampsia / Gestational Diabetes / etc.]

Required Plan of Care:
Due to the risks of [List potential complications, e.g., fetal growth restriction, maternal organ failure, or preterm birth], the following services are medically necessary for the duration of the pregnancy:

- Increased frequency of prenatal office visits (e.g., weekly or bi-weekly).
- Frequent maternal-fetal medicine (MFM) consultations.
- Regular fetal surveillance, including Non-Stress Tests (NST) and Biophysical Profiles (BPP).
- Serial ultrasounds for [growth monitoring / Doppler studies / cervical length].

Failure to provide this level of specialized care poses a significant risk to the health and safety of both the mother and the fetus. Continuation of this high-risk management is essential to mitigate these risks and ensure the best possible clinical outcome.

Please contact my office at [Phone Number] if you require additional clinical records or documentation.

Sincerely,

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