Date: [Insert Date]

To: [Physician Name]
Address: [Physician Clinic/Hospital Address]
Fax/Email: [Physician Contact Information]

RE: Updated Physician Certification Request

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Policy/ID Number: [Reference Number]

Dear Dr. [Physician Last Name],

We are writing to request an updated Physician Certification for the above-referenced patient regarding their ongoing [medical Necessity/disability/home health] requirements.

To ensure compliance with updated [Regulatory Body/Insurance Provider] directives, please review and complete the attached certification form. Your clinical documentation must support the following:

- Current diagnosis and functional limitations.
- The specific treatment plan or services required.
- The estimated duration of the continued need for care.
- Professional attestation and signature.

Please return the completed and signed documentation via fax to [Fax Number] or via secure email to [Email Address] by [Due Date]. Failure to provide this updated certification may result in a disruption of [benefits/services/coverage].

Thank you for your prompt attention to this matter and for your continued care of our mutual patient.

Sincerely,

[Your Name/Organization Name]
[Your Title]
[Your Phone Number]