

[Clinic Letterhead/Name]

[Clinic Address]

[City, State, Zip Code]

[Phone Number]

[Date]

To: [Insurance Provider / Relevant Authority Name]

Re: Ongoing Recertification of Chronic Condition

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Policy/ID Number: [ID Number]

To Whom It May Concern,

This letter serves as formal medical documentation for the ongoing recertification of treatment for [Patient Name], who remains under my care for the management of the following chronic condition(s):

- [Diagnosis Name / ICD-10 Code]
- [Diagnosis Name / ICD-10 Code]

The patient was originally diagnosed on [Date of Original Diagnosis]. Since the last certification period, the patient's condition is [Stable / Progressing / Requiring Adjustment]. Current clinical findings indicate that the patient continues to experience [List Primary Symptoms].

The current treatment plan includes:

- Medications: [List Medications and Dosages]
- Therapies: [List Physical/Occupational Therapy, etc.]
- Monitoring: [List Frequency of Follow-ups or Lab Work]

It is my professional medical opinion that continued treatment and monitoring are medically necessary to prevent the exacerbation of symptoms and to maintain the patient's current level of function. This condition is permanent and requires lifelong management.

The estimated duration for this ongoing care is [Indefinite / Number of Months].

Please contact our office at [Phone Number] if you require additional medical records or clinical notes regarding this recertification.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Clinic Name]