[Physician Name, MD/DO/Specialist]
[Clinic/Hospital Name]
[Medical Specialty]
[Address]
[Phone Number]
[Date]

RE: Specialist Chronic Illness Continuing Care Certification

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Patient ID/Policy Number: [ID Number]

To Whom It May Concern,

I am writing to formally certify the ongoing medical necessity of continuing care for the above-named patient. I have been the treating specialist for [Patient Name] since [Date of Commencement of Treatment] for the management of the following chronic condition(s):

- [Primary Diagnosis Name] (ICD-10 Code: [Code])
- [Secondary Diagnosis Name] (ICD-10 Code: [Code])

The patient's condition is chronic, complex, and requires specialized long-term management. At this time, the patient is undergoing the following course of treatment:

- [Medication Management/Infusion Therapy]
- [Regular Monitoring/Diagnostic Testing Frequency]
- [Specific Therapeutic Interventions]

Due to the nature of this illness, any interruption in the current specialized care plan would result in a significant decline in the patient's health status, increased risk of hospitalization, or permanent disability. Continuous monitoring and intervention by a specialist are required for the foreseeable future, estimated at [Duration/Indefinite].

I certify that the requested continuing care is medically necessary and meets the criteria for specialized chronic disease management. Please feel free to contact my office at [Phone Number] if you require additional documentation or clinical records.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[License Number/NPI Number]