Date: [Insert Date]

Patient Name: [Insert Patient Name]
Date of Birth: [Insert Date of Birth]
Patient ID/Policy Number: [Insert ID Number]

Subject: Annual Chronic Condition Medical Review Certification

To Whom It May Concern,

I am writing to formally certify that I have conducted the annual medical review for the above-named patient on [Insert Date of Review].

After a comprehensive clinical evaluation, I confirm that the patient continues to be treated for the following chronic condition(s):

- [Insert Chronic Condition 1] (ICD-10 Code: [Insert Code])
- [Insert Chronic Condition 2] (ICD-10 Code: [Insert Code])

The patient's current treatment plan includes:

- [Insert Medication/Therapy/Management Plan]

Based on my assessment, the patient remains stable under the current management plan, and continued care is medically necessary for the upcoming year. The next formal review is scheduled for [Insert Next Review Date].

Please update the patient's records to reflect this annual certification. Should you require additional documentation or clinical notes, please contact my office.

Sincerely,

[Physician Signature]
Physician Name: [Insert Name]
Medical License Number: [Insert License #]
Facility/Clinic Name: [Insert Facility Name]
Phone Number: [Insert Phone Number]