

[Physician Name, MD/DO]  
[Clinic Name]  
[Address]  
[City, State, Zip Code]  
[Phone Number]

[Date]

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

RE: Long-Term Disability Support for [Patient Name]  
Claim Number: [Claim Number]  
Date of Birth: [DOB]

To Whom It May Concern:

I am the treating physician for [Patient Name], who has been under my care since [Date]. This letter is to provide medical necessity documentation for [Patient Name]'s long-term disability claim due to chronic pain syndrome and associated conditions, including [List specific diagnoses, e.g., Fibromyalgia, Degenerative Disc Disease, Neuropathy].

Despite ongoing medical interventions including [List treatments, e.g., physical therapy, injections, nerve blocks, and pharmacological management], the patient continues to experience debilitating pain levels of [Pain Score] out of 10. This pain is characterized as [Constant/Intermittent] and is exacerbated by [Specific triggers].

Due to these medical conditions, the patient suffers from the following functional limitations:

- Inability to sit or stand for more than [Number] minutes at a time.
- Severe cognitive impairment ("brain fog") and loss of focus due to pain intensity and medication side effects.
- Limited range of motion in [Affected Area].
- Inability to lift, carry, or reach more than [Weight] pounds.
- Requirement for unscheduled breaks and periods of recumbent rest throughout the day.

In my professional medical opinion, [Patient Name] is unable to perform the material and substantial duties of their regular occupation or any other gainful employment. These restrictions are expected to be permanent/long-term in nature.

Please feel free to contact my office if you require further objective medical evidence or clinical records.

Sincerely,

[Physician Signature]

[Physician Printed Name]