Date: [Date]

To: [Insurance Company Name]
Attn: [Prior Authorization Department]
Fax: [Fax Number]

Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy ID: [ID Number]
Group Number: [Group Number]

Subject: Letter of Medical Necessity for Home Ventilator Support

To Whom It May Concern,

I am writing to request authorization for a home ventilator ([HCPCS Code, e.g., E0465 or E0466]) for my patient, [Patient Name].

Diagnosis:
The patient has been diagnosed with [Primary Diagnosis, e.g., Neuromuscular Disease, COPD, Chronic Respiratory Failure] (ICD-10 Code: [Code]).

Clinical Findings:
The patient presents with the following clinical indicators requiring mechanical ventilation:

- [Indicator 1: e.g., Arterial blood gas results showing $PaCO_2 > 45$]
- [Indicator 2: e.g., Forced Vital Capacity < 50% of predicted]
- [Indicator 3: e.g., Nocturnal oximetry showing significant desaturation]

Treatment History:
The patient has previously tried and failed [List previous treatments, e.g., CPAP or BiPAP] due to [Reason for failure, e.g., ineffective clearing of secretions, worsening hypercapnia].

Medical Necessity:
A home ventilator is medically necessary for this patient to maintain adequate gas exchange, reduce the work of breathing, and prevent frequent hospitalizations or life-threatening respiratory failure. The device is required for [Number] hours per day.

Please contact my office at [Phone Number] if further documentation is required.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Facility Name]