Date: [Insert Date]

To: [Insurance Company Name]
Attention: Medical Review/Prior Authorization Department
Address: [Insurance Company Address]

RE: Letter of Medical Necessity for Augmentative and Alternative Communication (AAC) Device

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

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to request coverage for a speech-generating device (SGD), specifically the [Name of Device/Software]. [Patient Name] has been diagnosed with [Primary Diagnosis, e.g., Autism, Cerebral Palsy, ALS] (ICD-10 Code: [Code]) and [Secondary Diagnosis, e.g., Expressive Language Disorder] (ICD-10 Code: [Code]).

Clinical Assessment:
The patient presents with a severe communication impairment that prevents them from meeting daily functional communication needs through natural speech. A comprehensive speech-language evaluation was completed on [Date], which determined that the patient's current speech is non-functional for [List reasons, e.g., interacting with caregivers, expressing pain, or emergencies].

Trial Results:
During a trial period from [Start Date] to [End Date], the patient was introduced to the [Device Name]. Using this device, the patient demonstrated the ability to [List specific outcomes, e.g., select icons to form sentences, navigate pages, or express specific needs]. The patient showed significantly higher proficiency with this device compared to [List other methods tried, e.g., PECS or low-tech boards].

Medical Necessity:
The requested AAC device is medically necessary to allow the patient to communicate basic needs, medical symptoms, and safety concerns. Without this device, the patient is unable to participate in their own medical care or social environment effectively. This equipment is not for environmental control or educational purposes; it is a prosthetic tool for functional communication.

Recommendation:
I recommend the following equipment and accessories:
- [Device Name and Model]

- [Software Name]
- [Mounting Equipment or Protective Case, if applicable]

Please contact me at [Phone Number] or [Email Address] if you require further documentation or clinical notes regarding this request.

Sincerely,

[Your Signature]
[Your Printed Name], [Credentials, e.g., MS, CCC-SLP]
[NPI Number]
[Facility Name]