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

RE: Letter of Medical Necessity for Custom Molded Orthotics
Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request coverage for custom-molded foot orthotics (HCPCS Code: L3000) for my patient, [Patient Name].

Diagnosis:
The patient has been diagnosed with the following condition(s):
- [ICD-10 Code and Description, e.g., M72.2 Plantar Fasciitis]
- [ICD-10 Code and Description, e.g., M21.41 Pes Planus/Flat Foot]

Clinical Findings:
Upon physical examination and biomechanical evaluation, the patient exhibits [mention symptoms, e.g., chronic heel pain, gait abnormality, or severe over-pronation]. These symptoms significantly limit the patient's [mention functional limitations, e.g., ability to walk, stand for extended periods, or perform daily activities].

Previous Treatments:
The patient has attempted conservative treatments including [list treatments, e.g., physical therapy, over-the-counter inserts, NSAIDs, or stretching exercises] for a duration of [number] months. These interventions have failed to provide adequate relief or correction.

Medical Recommendation:
Based on the patient's history and lack of response to conservative therapy, custom-molded orthotics are medically necessary to provide structural support, correct alignment, and prevent further deformity or surgery. Prefabricated inserts are insufficient for this patient due to [reason, e.g., the specific degree of deformity].

Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Physician Signature]
[Physician Name, Degree]
[NPI Number]
[Practice Name]