Date: [Date]
To: [Insurance Company Name]
Attention: [Claims/Appeals Department]
Fax/Address: [Fax Number or Address]

RE: Letter of Medical Necessity
Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Policy Number: [Insurance ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request coverage for the following Durable Medical Equipment (DME): **[Name of Equipment/Device]**. This equipment is medically necessary for the treatment of my patient, [Patient Name].

Diagnosis:
The patient has been diagnosed with [Primary Diagnosis Name] (ICD-10 Code: [Code]). Secondary conditions include [Secondary Diagnosis/Codes].

Clinical Justification:
The patient presents with [List specific symptoms, physical limitations, or clinical findings]. Due to these conditions, the patient requires [Equipment Name] to:

- [Reason 1: e.g., Improve mobility/safety]
- [Reason 2: e.g., Prevent further injury or hospitalization]
- [Reason 3: e.g., Support activities of daily living]

Previous Treatments:
We have previously attempted [List other treatments, medications, or less expensive equipment]. These interventions were unsuccessful or insufficient because [Reason].

Duration of Need:
The patient is expected to require the use of this equipment for [Number of months/years or "Lifetime"].

In summary, [Name of Equipment] is an essential component of this patient's treatment plan. Please contact my office at [Phone Number] if you require additional medical records or documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]

NPI Number: [NPI Number]
Practice Name: [Clinic Name]