Date: [Date]

To: [Insurance Company Name]
Attention: [Claims/Appeals Department]
Address: [Insurance Company Address]

RE: Letter of Medical Necessity for Custom Orthotics

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

To Whom It May Concern,

I am writing to formally request coverage for custom-fabricated foot orthotics (HCPCS Code: L3000/L3020) for the above-mentioned patient. This request is based on a thorough clinical evaluation and failure of conservative treatment options.

Clinical Diagnosis:
The patient has been diagnosed with: [ICD-10 Code and Description, e.g., M21.41 Pes Planus / M77.31 Plantar Fasciitis].

Medical History and Symptoms:
The patient presents with [Number] months/years of chronic pain located in the [Specific Area]. Physical examination reveals [Specific Findings, e.g., severe over-pronation, limb length discrepancy, or ulceration risks]. These symptoms significantly limit the patient's activities of daily living and mobility.

Previous Treatments:
Prior to this recommendation, the following conservative treatments were attempted without sufficient resolution of symptoms:

- [Over-the-counter inserts/arch supports]
- [Physical therapy]
- [Anti-inflammatory medications]
- [Activity modification]

Necessity of Custom Fabrication:
Prefabricated inserts are inadequate for this patient because [Reason, e.g., the degree of deformity requires specific biomechanical correction that retail inserts cannot provide]. Custom orthotics are medically necessary to [Goal, e.g., redistribute pressure, correct alignment, or prevent surgical intervention].

Please contact my office at [Phone Number] if further documentation is required to approve this claim.

Sincerely,

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