[Physician or Therapist Name/Title]
[Facility/Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

To: [Insurance Company Name]
Attn: [Claims/Appeals Department]
[Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Speech-Language Pathology Services

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Policy Number: [ID Number]
Group Number: [Group Number]
ICD-10 Diagnosis Code(s): [List Codes]

To Whom It May Concern,

I am writing to formally request coverage for skilled speech-language pathology intervention for [Patient Name]. This patient has been evaluated and diagnosed with [Diagnosis Name, e.g., Receptive/Expressive Language Disorder, Dysphagia, or Apraxia].

Clinical Assessment:
Based on the evaluation conducted on [Date], the patient presents with significant deficits in [List areas: e.g., verbal communication, swallowing safety, or cognitive processing]. Standardized testing scores indicate that the patient is functioning at the [Percentile/Age level], which is significantly below chronological age expectations.

Treatment Plan:
The prescribed treatment plan involves [Number] sessions per week for a duration of [Number] months. Therapy will focus on the following functional goals:

- [Goal 1]
- [Goal 2]

Medical Necessity:
These services are medically necessary to [Reason: e.g., prevent further regression, ensure safe nutritional intake, or develop functional communication for daily living]. Without regular skilled intervention, the patient is at high risk for [Complications: e.g., social isolation, nutritional compromise, or academic failure]. This treatment is not elective or educational; it is a rehabilitative necessity to address a diagnosed medical condition.

Please contact me at [Phone Number] if you require additional clinical documentation or progress notes.

Sincerely,

[Signature]
[Printed Name and Credentials]
[NPI Number]