

Date: [Date]

To: [Workers' Compensation Insurance Carrier Name]

Attn: Claims Department / Utilization Review

Address: [Insurance Company Address]

Fax/Email: [Fax Number or Email Address]

RE: Letter of Medical Necessity for Prescription Authorization

Patient Name: [Patient Full Name]

Claim Number: [Claim Number]

Date of Injury: [Date of Injury]

Date of Birth: [Patient DOB]

To Whom It May Concern,

I am writing to formally request authorization for the following prescription medication for the above-referenced patient regarding their work-related injury:

Medication Name: [Medication Name and Dosage]

Frequency: [Dosing Instructions]

Quantity/Duration: [Number of Days or Refills Requested]

Clinical Justification:

The patient is currently being treated for [Diagnosis/ICD-10 Code] resulting from the industrial injury sustained on [Date]. This medication is medically necessary because [Briefly describe medical reason, e.g., management of chronic pain, reduction of inflammation, or prevention of further injury].

Previous Treatments:

The patient has previously attempted the following treatments without success or with adverse reactions: [List previous medications, physical therapy, or alternative treatments].

Expected Outcome:

Failure to provide this medication will likely result in [Consequences, e.g., increased pain levels, inability to participate in rehabilitation, or delayed return to work]. With this treatment, the goal is for the patient to achieve [Goal, e.g., functional improvement or pain stabilization].

Please provide an expedited response to this request to ensure there is no interruption in the patient's care. If you require further documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Practice Name]

[NPI Number]