[Date]

[Claims Administrator Name]
[Company Name]
[Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity and Authentication of Treatment

Patient Name: [Patient Name]
Date of Birth: [DOB]
Claim Number: [Claim Number, if applicable]
Date(s) of Service: [Dates]

To Whom It May Concern,

I am writing to formally verify that [Patient Name] is under my professional care. This letter serves as authentication for the medical services and/or equipment provided to the patient as part of their treatment plan for [Diagnosis/Condition].

I confirm that the following services/items were medically necessary for the diagnosis and treatment of the patient's condition:

- [Service/Item 1]
- [Service/Item 2]

The aforementioned services were performed or prescribed by me in my capacity as a licensed [Physician Specialty]. All documentation submitted for this claim is an accurate representation of the care provided.

Please feel free to contact my office at [Phone Number] should you require additional information or further clarification regarding this patient's treatment.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[NPI Number]
[Medical Practice Name]
[Contact Email/Phone]