

Sample Letter of Medical Necessity

[Physician practice letterhead]

ATTN:

[Contact Name]

[Insurance Company Name]

[Insurance Company Street Address]

[Insurance Company City, State, Zip]

RE:

[Insured Patient Name]

Date of birth: [Patient DOB]

Policy number: [Policy #]

Group number: [Group #]

Dear [Personalize],

I am writing on behalf of my patient, [patient name], to document medical necessity and request approval to treat with [insert product name]. [Insert product name] is [insert brief product and indication description]. This letter provides clinical history, treatment rationale, and documentation to support the use of [insert product name] for treatment of [insert full name of condition/disease] for this patient.

[Mr./Mrs./Ms.] [Patient Name]'s medical history and course of treatment are as follows:

Summary of Patient's History

- [Patient's diagnosis, date of diagnosis]
- [Laboratory results and dates]
- [Brief description of patient's current medical condition]
- [Patient's previous and current treatments/therapies]
- [Patient's response to those treatments/therapies]
- [If the patient has discontinued, include information on lack of response or tolerability, if applicable]
- [Any additional pertinent information]

In my clinical opinion, [Mr./Mrs./Ms.] [Patient name] should receive [insert product name] for the following reasons, with applicable supporting documentation enclosed:

Rationale for Treatment

- [Insert reasons]
- [Attach any relevant medical literature]
- [Attach any relevant clinical documentation]

In summary, [insert product name] is medically necessary and reasonable for [Mr./Mrs./Ms.] [Patient Name]'s medical condition. Please call my office at [telephone number] if you require any additional information or documentation. I look forward to your timely response.

Sincerely,

[Insert Physician Name and Participating Provider Number]