

# PATIENT LETTER OF MEDICAL NECESSITY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_

Physician NPI Number: \_\_\_\_\_

Practice Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## **Medical Diagnosis and Clinical Indications:**

Please describe the patient's medical diagnosis, including relevant ICD-10 codes. Explain the clinical indications necessitating the prescribed equipment or service, and the expected benefits to the patient. Include pertinent history, symptoms, and any prior treatments that have been tried and their outcomes.

## **Prescribed Equipment/Service:**

Specify the exact equipment or service being prescribed, including brand, model, size, and quantity if applicable. Explain why this specific equipment or service is medically necessary for the patient's condition.

## **Medical Necessity Justification:**

Provide the rationale for the medical necessity of the prescribed equipment or service. Include references to clinical guidelines, peer-reviewed literature, or best practices that support this prescription. Address any alternative treatments considered and why they are not appropriate or sufficient.

## **Functional Limitations and Impact on Daily Living:**

Describe the patient's functional limitations that necessitate this equipment or service. Explain how these limitations impact the patient's activities of daily living (ADLs) and quality of life.

## **Duration of Need:**

Indicate the anticipated duration of medical necessity for the equipment or service. If temporary, specify expected length of use. If long-term or permanent, state accordingly.

## **Additional Relevant Information:**

Include any additional information pertinent to the patient's care, such as special considerations, contraindications, or coordination with other healthcare providers.

This letter is provided to support the medical necessity of the prescribed equipment or service in accordance with applicable United States laws, regulations, and payer policies. The information contained herein is accurate to the best of the undersigned physician's knowledge and belief, and is intended to facilitate coverage and reimbursement decisions.

**Prescribing Physician Signature**

**Patient Signature**

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

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