**Writing a Letter of Medical Necessity Template**

(a template without instructions is at the end of this page)

Date: [insert date]

Medical Director: [Name, or write “To Whom It May Concern”]

Health Plan: [Name of plan]

Address: [Address of plan]

Fax: [Fax # of plan]

Regarding: [Patient Name]

Date of Birth: [Patient DOB]

Insurance ID number: [Patient Insurance #]

Greetings:

I am writing to request [insert treatment/medication/service/equipment/item in question] for my patient [name of patient] who has the following diagnosis (or diagnoses) related to this request:

* [Use the most specific diagnosis or diagnoses as appropriate for the request. Avoid non-specific diagnoses like “fatigue,” “bone pain,” or “weakness”; “osteoporosis related to quadriplegic cerebral palsy” is specific.]

Prior to this request, [patient’s name] has undergone (tried/been treated with) [insert information on the course of care and treatment up to this point; some insurers may require that specific interventions be tried before requesting a more expensive approach].

[Name of patient] now needs [insert the treatment/medication/service/equipment/item in question and explain how you expect it will help the patient] for [insert duration, though approval will often not exceed 12 months].

This request is medically necessary for the following reasons [list one or more of the following reasons]:

* It will, or is reasonably expected to, prevent the onset of an illness, condition, or disability. [Then provide more details; including supporting clinical guidelines, expert guidance, or best practices when available.]
* It will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, injury, or disability. (Then provide more details, including supporting clinical guidelines, expert guidance, or best practices when available.)
* It will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age. [Then provide details about this; include supporting clinical guidelines, expert guidance, or best practices when available.]

In summary, [insert specific treatment/medication/service/equipment/item in question and duration] is medically necessary for this patient’s medical condition. Please contact me if any additional information is required to ensure the prompt approval of [insert treatment/medication/service/equipment/item in question].

Sincerely,

[Insert physician’s name, signature, and date]

**Additional letter-writing tips: Be specific and include this information:**

Cite past successes with the treatment.

Cite recent medical articles.

Include letters from consultants including physical or occupational therapists

Review previous and failed treatments.

Address the insurer’s suggested treatments.

Be specific about psychological factors that are relevant to your chosen treatment.

Provide information you have which a distant administrator may not know.

Cite conversations with family members or other treating physicians.

**Template without Instructions for Letter of Medical Necessity**

(Use the physician/provider’s letterhead)

Date: \_\_\_

Medical Director: \_\_\_

Health Plan: \_\_\_

Address: \_\_\_

Fax: \_\_\_

Regarding: \_\_\_

Date of Birth: \_\_\_

Insurance ID number: \_\_\_

Greetings:

I am writing to request \_\_\_ for my patient \_\_\_ who has the following diagnoses relevant to this request:

* \_\_\_
* \_\_\_

Prior to this request, \_\_ has tried \_\_\_.

\_\_\_ now needs \_\_\_ for \_\_\_

This request is medically necessary for the following reasons:

* It will, or is reasonably expected to, prevent the onset of an illness, condition, or disability. \_\_\_
* It will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, injury, or disability. \_\_\_
* It will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age. \_\_\_

In summary, \_\_ is medically necessary for this patient’s medical condition. Please contact me if any additional information is required to ensure the prompt approval of \_\_\_.

Sincerely, \_\_\_