Sample Letter of Medical Necessity

This sample letter is for demonstration purposes only. It provides an example of the type of information that may be required when responding to a request from a patient's insurance company for an appeal of coverage. Use of this template or the information in this template does not guarantee reimbursement for coverage. It is not intended to be a substitute for or to influence the independent clinical decision of the prescribing healthcare professional.

[Date]
[Insurance Company Contact]
[Insurance Company Name]
[Insurance Company Address]
[Insurance Company City, State, ZIP]

Re:
Patient: [Patient's First and Last Name]
Subscriber ID #: [Insurance Subscriber ID]
Subscriber Group #: [Insurance Group ID]
Date of Birth: [Patient's Date of Birth]

Dear [Insurance Company Contact]:

I am writing on behalf of my patient, [Patient's First and Last Name], to demonstrate medical necessity and support for the coverage of [medication name] for oral inhalation use. [Indication and ICD-10 code]

I have read and acknowledge your policy for the responsible management of drugs in this category. In this letter, I provide my rationale for the use of [medication name] by [Patient's First and Last Name]. I have also included a brief description of the patient's medical history, including prior therapies, and their current condition and diagnosis.

[Provide details on the patient's diagnosis, current condition, symptoms, treatment history, and support for approval, including the following:

- Records indicating the patient's diagnosis and the date of diagnosis
- Rationale for treatment
- Brief description of the patient's disease state
- Comprehensive list of any prior treatments and response to those treatments
- Rationale for selecting [medication name]
- Additional clinical support for the appeal
- Additional medical documentation or studies that support your argument for approval]

Based on the above information, I hope that you will agree that [medication name] is medically necessary for this patient.

Please contact my office by calling [Practice Phone Number] for any additional information you may require in support of coverage for [medication name]. I look forward to your timely approval.

Sincerely,

[Physician's Signature]

[Physician's Name]
[Provider Identification Number]
[Name of Practice]
[Phone Number]

[Patient's Signature]

[Patient's Name]

Enclosures: (attach as appropriate)

- Prescribing Information (PI)
- Patient clinical/diagnostic notes and relevant lab reports