Letter of Medical Necessity

Payers may require prior authorization or supporting documentation in order to process and cover a claim for the requested therapy. Prior authorization allows the payer to review the reason for the requested therapy and to determine medical appropriateness.

A patient-specific letter of medical necessity will help to explain the physician's rationale and clinical decision-making in choosing a therapy. The following is a sample letter of medical necessity that can be customized based on your patient's medical history and demographic information. Please note that some payers may have specific forms that must be completed in order to request prior authorization or to document medical necessity.

From: _____

Sender's (Physician's) Name

_____

Provider Identification Number (PIN)

_____

_____

Sender's Address

_____

City, State, ZIP Code

_____

Date

To:_____

Contact Name of Medical Director or Other Payer Representative

_____

Contact Title

_____

Contact Address

_____

City, State, ZIP Code

Re: Letter of Medical Necessity for [Product] [Strength]

Dear _____,

Insert Contact Name or Department

I am writing on behalf of my patient, [Patient Name], group/policy number [Number], date(s) of service - [Dates]. I would like to [request prior authorization/document medical necessity] for treatment with [Product]. [Product] is indicated for the treatment of [Indication Statement].

This letter serves to document that [Patient Name] has a diagnosis of [Diagnosis] and needs treatment with [Product] and that [Product] is medically necessary for them as

prescribed. On behalf of the patient, I am requesting approval for use and subsequent payment for the treatment.

Patient Medical History and Diagnosis

[Patient Name] is a [Age]-year-old [Male/Female] diagnosed with [Diagnosis]. [Patient Name] has been in my care since [Date]. As a result of [Diagnosis], my patient [a brief description of patient history]. Additionally, [Patient Name] has tried [Previous Therapies] and [Outcomes]. The attached medical records document [Patient Name]'s clinical condition and medical necessity for treatment with [Product].

Based on the above facts, I am confident that you will agree that [Product] is indicated and medically necessary for this patient. The plan of treatment is to start the patient on [Product] and monitor and follow up as appropriate.

Please consider coverage of [Product] on [Patient Name]'s behalf, and approve use and subsequent payment for [Product] as planned. Please refer to the enclosed Prescribing Information for [Product]. If you have any further questions regarding this matter, please do not hesitate to call me at [Sender's (Physician's) Telephone Number]. Thank you for your prompt attention to this matter.

Sincerely,

[Sender's (Physician's) Name], [Degree Initials]

[Provider Identification Number (PIN)]

Enclosures: (Attach as appropriate)

- FDA Approval Letter;
- Prescribing Information (PI);
- Clinic Notes & Labs.

CC: Medical Director, Patient, Specialty Society, Insurance Commissioner