SAMPLE LETTER OF MEDICAL NECESSITY

Payers may require prior authorization or supporting documentation in order to process and cover a claim for the requested therapy. A 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.*

[Date]

[Contact Name of medical director or other payer representative]
[Contact Title]
[Name of Health Insurance Company]
[Address]
[City, State, Zip]

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

Patient: [Patient Name]
Group/policy Number: [Number]
Date(s) of service: [Dates]
Diagnosis: [Code & Description]

Dear [Insert contact name or department]:

I am writing on behalf of my patient, [PATIENT NAME], to [REQUEST PRIOR AUTHORZATION/DOCUMENT MEDICAL NECESSITY] for treatment with [Product]. [Product] is indicated for 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 [him/her] 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]. [NAME OF PATIENT] has been in my care since [DATE]. As a result of [DIAGNOSIS], my patient [ENTER BRIEF DESCRIPTION OF PATIENT HISTORY]. Additionally, [PATIENT] 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], monitor platelet count and response to therapy and adjust dose accordingly.

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 [PHYSICIAN TELEPHONE NUMBER]. Thank you for your prompt attention to this matter.

Sincerely,
[PHYSICIAN NAME], <DEGREE INITIALS>
[PROVIDER IDENTIFICATION NUMBER]

Enclosures: (Attach as appropriate)
FDA approval letter
Prescribing Information (PI)
Clinic notes & labs

CC: [Medical Director, patient, specialty society, Insurance Commissioner]