Sample Letter of Medical Necessity

(Practice Letterhead)

(Date)

(Payer Name)
(Payer Representative)
(Payer Address)
(City, State ZIP Code)
(Payer Fax Number)

Attention: **(Payer Representative)**
Attention: **(Department Name)**

Re: Coverage of **(Product Name)® (Generic Name)**
Subscriber: **(Subscriber's First and Last Name)**
Patient Name: **(Patient's First and Last Name)**
Policy # / Patient ID: **(Policy Number / Patient's ID)**
Group #: **(Group Number)**
Patient Date of Birth: **(Patient Date of Birth)**
Patient Age: **(Patient Age)**
Patient Sex: **(Patient Sex)**

Dear Medical or Pharmacy Director:

I am writing on behalf of **(Patient's name)**, **(policy #)**, to document the medical necessity of **(Product Name)®.**

(Mr/Mrs/Ms) (Patient's name) was provided with **(Product Name)®**. The full Prescribing Information for **(Product Name)®** can be accessed at www.**(product name)**.com.

(Mr/Mrs/Ms) (Patient's name)'s medical history and course of treatment are as follows:

(Describe the patient's history, diagnosis, and previous and current treatment regimens and their outcomes. NOTE: Physicians should exercise medical judgment and discretion in regard to making an appropriate diagnosis and characterization of an individual patient's medical condition. In addition, physicians are responsible for ensuring the accuracy and validity of all billing and claims for appropriate reimbursement.)

In my clinical opinion, **(Mr/Mrs/Ms) (Patient's name)** should receive **(Product Name)®** for the following reasons:

- **(List reasons)**

In summary, **(Product Name)®** is medically necessary and reasonable for **(Mr/Mrs/Ms) (Patient's name)'s** medical condition. Please contact me if any additional information is required to ensure the prompt approval of this course of treatment.

Sincerely,

(Physician's name)