[Date]

[Payer Name]

[Payer Street Address]

[Payer City, State Zip]

Re: [Patient Full Name]

 [Patient Policy Number]

[Patient Member ID]

[Patient Date of Birth]

[Patient Diagnosis/ICD-10]

 [Prior Authorization or Claim Number]

 [Date(s) of Service]

To Whom It May Concern:

I am writing to provide additional information to support my [prior authorization request / claim] for the treatment of [Patient Name] with [insert product name here].

In brief, treatment of [Patient Name] with [insert product name here] is medically appropriate and necessary and should be a covered and reimbursed service. This letter outlines [Patient Name]’s medical history, prognosis, and treatment rationale.

**Summary of Patient’s History**

[You may want to include:

* Patient’s diagnosis, condition, and history
* Previous therapies the patient has been treated with
* Patient’s response to these therapies
* Brief description of the patient’s recent symptoms and conditions
* Summary of your professional opinion of the patient’s likely prognosis without this specific product

It is important to ensure that the patient meets the medical necessity criteria outlined within the respective insurance medical policy or Medicare LCD/Article.]

**Rationale for Treatment**

Given the patient’s history, condition, and the published data supporting use of [insert product name here], I believe treatment of [Patient Name] with [insert product name here] is warranted, appropriate, and medically necessary.

Please call my office at the number listed below if I can provide any additional information. I look forward to receiving your timely response and approval of this [prior authorization request / claim].

Sincerely,

[Physician Signature]

[Physician Name]

[Physician Street Address]

[Physician City, State, Zip]

[Participating Provider Number]

[Physician Phone Number]

Enclosures [Attach additional supporting documents (such as patient’s treatment with this specific product, medical history, diagnosis, lab results, and treatment plan).]