[Date]

[Medical Director Name]

[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/ 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

**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 claim.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[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).]