Sample Letter of Medical Necessity
Physician's Letterhead

[Insurance Company]
[Address]
[City, State, Zip]

Re: [Patient Name]
[Policy #]
[DOB]
[Address]
[City, State, Zip]

To Whom It May Concern:

I am writing on behalf of my patient, **[*Patient Name, ID and Group Number*]** to appeal for the coverage of **[Product name (generic name)]** for the treatment of ***[Diagnosis]***. This letter of medical necessity includes the patient's relevant past medical history, overview of prior care delivered, treatment rationale and supporting medical necessity data.

Patient's History, Past Treatments and Drugs Utilized:
[Include information outlining when the patient was diagnosed and severity of symptoms]

Treatment Rationale:
[Include information on past treatments and drugs utilized to treat the patient. Explain, as applicable, how the past treatments and drugs either did not effectively treat the patient, put the patient at risk, or other reasons for now prescribing Product name (generic name)].

Supporting Study Data
[Include references to published medical study data evaluating the use of Product name (generic name)]. Remember to include the FDA approved indications and usage.

In summary, in my medical judgement, **[Product name (generic name)]** is medically necessary for this patient's medical condition. Please contact me if any additional information is required to ensure the prompt approval **[Product name (generic name)]**.

Sincerely,

[Physician Name and Signature]
[Phone #]