

Sample Letter of Medical Necessity
Physician's Letterhead

Please Note: By downloading materials from this website, you agree to all of the following. These materials are available for download and public personal use. These materials have no value and are not to be re-sold or repurposed. They are solely for your personal use. No purchase from or relationship with IPSEN is required to download or use these materials. IPSEN makes no representations or warranties about these materials or their fitness for any specific use. IPSEN is not responsible for any changes made to these template documents. All billing and coding decisions are the responsibility of the relevant physician. IPSEN does not guarantee any specific reimbursement or favorable results.

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