LETTER OF MEDICAL NECESSITY

Healthcare Provider Information:

Name: _____

Title/Position: _____

Medical Facility/Organization: _____

Address:_____

City, State, Zip: _____

Phone: _____

Email: _____

Date: _____

Insurance Information:

Insurance Company Name: _____

Address: _____

City, State, Zip: _____

Patient Information:

Name: _____

Insurance ID Number: _____

Date of Birth: _____

Address: _____

City, State, Zip: _____

Subject: Request for Coverage:

[X] Equipment

Name/Description of Requested Item: High efficiency air conditioning filters

Diagnosis Requiring This Item: _____

ICD-10 Code: J67.7,_____

Medical History and Diagnosis:

Provide a brief overview of the patient's medical history and current diagnosis.

_____

Treatment Rationale:

Explain why the requested treatment, medication, or equipment is necessary.

_____

Duration:

Provide specifics about the treatment duration, or equipment specifications.

_____

Provider's Statement:

I hereby certify that the above information is true and accurate to the best of my knowledge and that the requested [treatment/medication/equipment] is medically necessary for the treatment of the above-named patient.

Provider's Signature: _____

Date: _____