BENEFIT EXPLAINED

LETTER OF MEDICAL NECESSITY

Patient Name: _____

Date of Birth: _____

Today's Date: _____

1. Medical Diagnosis

I certify that the above-named patient is under my care for the following medical condition(s):

_____

_____

2. Recommended Treatment / Item

To treat or alleviate this specific medical condition, I recommend the following product, service, or treatment:

_____

3. Duration of Treatment

☐ One-time purchase

☐ Ongoing for 12 months (Re-evaluation required after 1 year)

☐ Lifetime (Chronic Condition)

☐ Specific length of treatment: _____

4. Medical Necessity Statement

This treatment/product is medically necessary to diagnose, cure, mitigate, treat, or prevent the disease or condition listed above. It is **not** for general health, wellness, or cosmetic purposes.

Physician Signature: _____

Physician Name (Print): _____

NPI / License #: _____

Practice Phone: _____