**Letter of Medical Necessity**

(This letter will remain in effect for current year only.)

The letter of medical necessity is required with each claim filing and should be completed by the attending physician. Physician will need to specify that treatment is medically necessary for the patient’s specific condition which they are being seen for.

Please enter the following information to its entirety

**Name:**

**Address:**

**Patients DOB:**

**Contact Number:**

**PATIENT MEDICAL INFORMATION**

Assistive Device or service needed:

Describe the diagnosed condition to be treated:

Describe the recommended treatment:

Is medication approved for over the counter purchase? Yes **[ ]**  No **[ ]**

Indicate the duration of the treatment:

**FOR PHYSICIAN OFFICE USE ONLY**

Please Read the following and sign/ date

I agree that the treatment is medically necessary to treat the medical condition above for the specified patient. This treatment is not for general health purposes, to improve the appearances or for cosmetic services.

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_