Sample Letter of Medical Necessity

[Insert Date]

[Medical Director]
[Insurance Company] [Address]
[City, State, ZIP]
RE: Patient Name: **[Insert Patient Name]** Policy Number: **[Insert Policy Number]** Claim Number: **[Insert Claim Number]**
Subject: Coverage of **[Drug Name]**

Dear **[Insert Medical Director's Name]**:

I am writing to provide additional information to support my claim for the treatment of **[Patient Name]** with **[Drug Name]** for **[Disease]**. In brief, treatment of **[Patient Name]** with **[Drug Name]** is medically appropriate and necessary and should be a covered and reimbursed service.

This letter outlines **[Patient Name]**'s medical history, diagnosis, and treatment rationale.

Summary of Patient's History

[Note: Exercise your medical judgement and discretion when providing a diagnosis and characterization of the patient's medical condition. You may want to include the following information:]

- Patient's diagnosis and medical history
- Previous therapies the patient has received for their condition
- Patient's response to these therapies
- Brief description of the patient's recent presentation
- Summary of your professional opinion of the patient's likely prognosis without treatment with **[Drug Name]**

Rationale for Treatment

Given the patient's history, condition, and the supporting clinical information, I believe treatment of **[Patient Name]** with **[Drug Name]** is warranted, appropriate and medically necessary. **[Drug Name]** is indicated for **[Drug indication]**. The accompanying prescribing information provides the approved clinical information for **[Drug Name]**.

In summary, **[Drug Name]** is medically necessary and reasonable for **[Patient Name]**'s medical condition. Please contact me if any additional information is required to ensure the prompt approval of this course of treatment.

Sincerely,
[Treatment Provider's Signature] [Treatment Provider's Name Printed] [Treatment Provider's Phone Number]

Enclosures:
[Drug Name] prescribing information Statement of Medical Necessity form Other supporting documentation

This sample letter is for demonstration purposes only. It provides an example of the type of information that may be required when responding to a request from a patient's insurance company for an appeal of coverage. Use of this template or the information in this template does not guarantee reimbursement or coverage. It is not intended to be a substitute for or to influence the independent clinical decision of the prescribing healthcare professional.