

[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]

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[Treatment Provider's Name Printed]
[Treatment Provider's Phone Number]

Enclosures:

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

SAMPLE