Sample Letter of Medical Necessity for [Product Name]

This sample letter is a guide to help you document the need for a medication for your patient to obtain coverage for it through their health insurance plan. It is for informational purposes only and does not constitute medical, legal, or reimbursement advice and represents no statement, promise, or guarantee of coverage or payment. Always check to see if the patient’s health insurance has their own template for you to follow when submitting a letter of medical necessity. Individual health insurance policies are frequently updated and it is the

responsibility of the provider and/or their office staff to determine appropriate coding, medical necessity, site of service, and documentation requirements, and to submit appropriate codes, modifiers, and charges for services rendered, as specified by the patient’s health insurance.

[Date of service]

ATTN:

[Name of health insurance company] [PO Box or street address]

[City], [State] [Zip code] [Phone]

[Fax]

Subject: Intent to treat with [Product name] Dear [Payer medical director/contact name],

RE:

[Patient name] [DOB]

[Parent/Legal guardian’s name] Policy number: [Policy number] Group number: [Group number]

Medicaid number (if applicable): [Medicaid number]

I am writing to request authorization for my patient, [Patient name] , for treatment with [Product

name]. [Product name] is indicated for [Product indication].

[Patient name] was diagnosed with [Diagnosis name] on [month]/[date]/[year] and has been under my care since [month]/[date]/[year]. This letter outlines [Patient name] ’s medical history, treatment rationale, and documentation to support the use of [Product name] for treatment of [disease/condition].

**Summary of Patient Medical and Treatment History**

[Patient’s name] ’s medical history:

Description of [Patient’s name] ’s current symptoms that support diagnosis:

Current treatment regimen include(s):

|  |  |  |
| --- | --- | --- |
| **Name of treatment** | **Patient response** | **Start date** |
|  |  |  |

Previous treatment include(s):

|  |  |  |
| --- | --- | --- |
| **Name of treatment** | **Patient response** | **Date of discontinuation** |
|  |  |  |

My professional opinion on the patient’s potential prognosis if treated with [Product name], based on published data and information available in the full Prescribing Information [attached]:

Given the information above, I strongly believe [Product name] is medically necessary and appropriate for the treatment of [disease/condition] for [Patient name] .

Please promptly review the information provided in order to authorize treatment and approve

[Patient name] ’s coverage for [Product name]. If you have any questions or require additional information to approve this request, please contact my office immediately using the information below.

Thank you for your attention to this very important matter. I look forward to your response and approval of this treatment request.

Sincerely,

[Physician name] [Credentials] [Physician address] [Physician phone number] [Physician email address]

**Enclosures** [suggested]

[Product name Prescribing Information] [Product name FDA Approval Letter] [Relevant medical records, clinical trials data]

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