

Instructions for Completing the Sample Letter of Medical Necessity

Sample Letter of Medical Necessity

This sample letter is intended to highlight the type of information that may be helpful in crafting a letter of medical necessity for your patient. This guide is for informational purposes only and does not constitute medical, legal, or reimbursement advice and it makes no guarantee of coverage or reimbursement for any Verona product. Requirements may vary by plan and individual health insurance policies are updated frequently. Plans may require the use of a specific template or form when submitting a letter of medical necessity. It is the responsibility of the healthcare provider and/or office staff to ensure all necessary information is provided and accurate.

[Institution Letterhead]

[Date]

ATTN:	RE:
[Health Plan]	[Patient name]
[Address]	[Date of birth]
[City, State, ZIP Code]	Policy number: [Policy number]
[Phone]	Group number: [Group number]
[Fax]	Medicare Beneficiary Identifier (if applicable): [MBI]
	Medicaid number (if applicable): [Medicaid number]

Subject: Request for treatment with [Brand name (generic)] for [diagnosis] [(ICD-10-CM code)]

Dear [Medical Director/Pharmacy Director/Payer contact],

I am writing to request authorization for [Brand name] for my patient [Patient name] for the treatment of [diagnosis]. This letter outlines [Patient name]'s medical history, my treatment rationale, and documentation to support the use of [Product name] for treatment of [diagnosis].

Patient Medical history and diagnosis

[Patient name] is [age] years old and was diagnosed with [diagnosis, ICD-10-CM code] on [diagnosis date]. [Patient name] has been under my care since [month]/[day]/[year].

Symptoms and diagnostics:

[Description of patient's symptoms and tests supporting diagnosis and request]

Treatment rationale:

[Include rationale for why the requested treatment is medically necessary and why other treatments on formulary are not appropriate for your patient.]

This may include

- Symptoms and disease severity
- Current and previous treatments, treatment durations, and clinical response
- Contraindications and allergies
- Other pertinent patient factors]

Current treatments for [diagnosis]:

Treatment	Patient response	Start date

Previous treatments tried and failed:

Treatment	Patient response	Date of discontinuation	Reason for discontinuation

Additionally, please see [list documents included with the submission, such as clinical notes on patient history, recent test results and diagnostics, product labeling, relevant publications] included with this request.

Based on the information above, I believe [Brand name] is appropriate and medically necessary for [Patient name] and request that you cover this treatment. If you have any questions about this request, please contact me at [Physician number and email].

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

Title

Signature

Phone number

Email address]

Enclosures: [Suggested enclosures include

- [Brand name] Prescribing Information
- FDA approval letter for [Brand name]
- Relevant medical records and test results
- Relevant publications, including clinical trials and treatment guidelines]



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Patient Medical history and diagnosis

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Symptoms and diagnostics:

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Treatment rationale:

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Current treatments for

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Treatment	Patient response	Start date

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Additionally, please see

included with this request.

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

Sincerely,

Enclosures:



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