Medical Necessity Letter

Date: _____ dd / mm / yyyy

Recipient Address Line 1: _____

Recipient Address Line 2: _____

Recipient Address Line 3: _____

Subject: _____

Recipient Name: _____

Treatment/Service/Equipment: _____

Patient Name: _____

Patient Age: _____

Physician Role: _____

Treatment/Service/Equipment: _____

PATIENT INFORMATION:

Patient's Name: _____

Date of Birth: _____ dd / mm / yyyy

Diagnosis/Condition: _____

Medical History

JUSTIFICATION FOR MEDICAL NECESSITY:

Justification

Details:

Name of Treatment, Procedure, or Medical Equipment:

Purpose/Intended Outcome

Duration/Frequency/Duration of Use: _____

Treatment/Service for request: _____

Patient name for request: _____

Contact Phone: _____

Contact Email: _____

Physician Signature

Physician Name: _____