Sample Letter of Medical Necessity

Date of request: [Date]

ATTN:
[Contact name]
[Health plan name]
[Health plan address]
[City, State ZIP Code]
[Fax number]

RE: Letter of Medical Necessity for [Product name]
[Insured Patient First Name Patient Last Name]
Date of birth: [Month Day, Year]
[Policy #][Group #]

To whom it may concern:

My name is [Provider First Name Provider Last Name, medical specialty (National Provider Identifier number)], and I am writing on behalf of [Patient First Name Patient Last Name] to request approval to treat [Patient name] with [Product name]. [Patient name] has been in my care since [Month Day, Year], for the [FDA-approved indication].

Based on my clinical judgment, I believe that [Product name] is specifically medically necessary for [patient name] because [rationale for prescribing [Product name]].

Please promptly review the enclosed information in order to authorize treatment of [Product name] for [patient name]. My office can be contacted at [phone number] or [email address] if additional information is required to approve this request. Thank you in advance for your timely attention to this matter.

Sincerely,

[Physician name, medical specialty, National Provider Identifier number]
[Physician address]
Phone number: [Physician phone number] Fax number: [Physician fax number]

Enclosures [for consideration]:
[Relevant patient medical records]
[Prescribing Information]
[FDA Approval Letter(s)]
[Peer-reviewed literature (eg, treatment guidelines)]
[National Headache Foundation Position Statement]