MD/DO Name: _____

Address: _____**City:**_____

Tel: _____ **Fax:** _____

NPI#: _____

LETTER OF MEDICAL NECESSITY

Patient name:	DOB:
Address:	St: Zip:
Phone:	Ins/Id:

I am writing in regards to the above named patient.
This letter is to serve as Medical Necessity for durable medical equipment prescribed for her daily living. The above named patient has been under my care for various complaints.

My clinical exam results are as follows:

PLAN/Recommendations:

LENGHTH OF NEED = 99 (UNLESS OTHERWISE NOTED)

Diagnosis Codes:

It is in my best professional opinion that all above durable medical equipment prescribed **ARE MEDICALLY NECESSARY.**

I have attached a copy of the patient's history and progress notes from the patients chart. Should you have any questions, please contact my office.

I look forward to your prompt attention to this matter.
Thank you for your assistance.

Sincerely,

_____ _____

PHYSICIAN'S SIGNATURE DATE