

WOCN® SOCIETY

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Letter of Medical Necessity Template (2)

Date:

[Contact – Name of Medical Director or other Payer Representative]

[Contact Title]

[Name of Insurance Company]

[Address]

[City, State, ZIP Code]

Insured: [Patient Name]

Policy Number: [Policy Number]

Group Number: [Group Number]

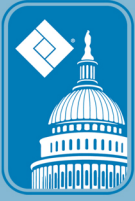
Dear [Insert appropriate contact name or department]:

I am writing on behalf of my patient, [patient name], to [request prior authorization/document medical necessity] for [insert name of service(s), procedure(s), or product(s)] for [insert treatment details] of [his/her] wound in the Wound Treatment Program at [list facility]. This letter provides information about the patient's condition, medical history, and treatment rationale, as well as scientific literature demonstrating medical necessity for [service(s)/product(s)/procedure(s)].

Patient History and Diagnosis

[Patient name] is a [age]-year-old [male/female] with a diagnosis of [diagnosis and ICD-9-CM diagnosis code] as of [date of diagnosis]. [Patient name] has been in [my or treating physician's name] care for [patient's diagnosis] since [date]. As a result of [patient's diagnosis], [he/she] [describe resulting condition, including results from any relevant patient lifestyle assessment]. [Provide a brief discussion of patient's condition/symptoms and therapy to date, including other treatments attempted and results.]

[Provide a brief discussion of service(s), product(s), and/or procedure(s), including supportive documentation and current peer-reviewed literature.]



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Based on the above facts, I am confident you will agree that [service(s)/procedure(s)/product(s) is/are] indicated and medically necessary for [name of patient's] treatment. If you have any further questions or require additional information regarding this patient's treatment, please feel free to call me at [phone number]. Thank you in advance for your immediate attention to this request.

Sincerely,

[Provider Name]