

Medical Necessity Letter

Date:

To:

From:

Patient Name:

Date of Birth:

Dear ,

I am writing on behalf of my patient, , to document the medical necessity for .

Patient's diagnosis:

ICD-10 Code:

The above-named patient requires the following treatment/service:

Duration or frequency:

This treatment is necessary because:

Please feel free to contact me at if you need additional information.

Sincerely,