Letter of Medical Necessity Inherited Metabolic Diseases

Date: _____ Insurance Company: _____ Member ID: _____

Patient Full Name: _____ DOB: _____

Patient Age: _____ Height: _____ Weight: _____

Medical Condition: ICD-10: _____ CPT/HCPCS Code: _____

Brief sentence of the disease/disorder: _____

_____

Physician's Name: _____ Clinic Name: _____

To Whom It May Concern:

This metabolic disease was diagnosed through newborn screening/lab tests and results, which are mandated by law in the U.S. The purpose of this letter is to explain the medical necessity of (Insert Product Name) and request insurance coverage for this treatment.

(Insert Disease/Disorder Name) is a life-long inherited metabolic disease (briefly describe disorder):

Treatment for (Insert Disease/Disorder Name) involves:

If (Insert Disease/Disorder Name) is not treated properly or promptly it can lead to the following health consequences:

(Insert Consequence #1) (Insert Consequence #2) (Insert Consequence #3)

Enteral formula (Insert Product Name) is considered XX % of her/his sole source of dietary nutrition as well as medically necessary. (Insert Formula) will provide XX % of patient's protein needs. It is essential to note that our patient's formula – (Insert Product Name) is specifically designed to treat her/his (Insert Disease/Disorder Name) . If our patient is untreated for (Insert Disease/Disorder Name) with (Insert Formula) , it would severely damage her/his health and fail to comply with diet restrictions.

(Insert Patient's Full Name) is currently prescribed (Insert Product Name) , a medical food formulated to meet the specialized nutrient needs of patients with (Insert Disease/Disorder Name) fed orally or enterally. The prescribed medical food is imperative in the treatment of (Insert Patient's First Name) condition. (Insert Product Name) is medically necessary to ensure that she/he maintains metabolic control.

It is essential to note that without our patient's medical food, it would be impossible to prevent chronic and severe hunger and fail to comply with diet restrictions.

In summary, (Insert Patient's Full Name) is in need of (Insert Product Name) , medical formula for treatment of (Insert Disease/Disorder Name) , ICD-10: XX-XXX . This patient has led a healthy life thus far; continued careful therapy will assure that this continues to be the case. If you have further questions, please do not hesitate to contact us at 000-000-0000 .

Sincerely,

(Insert Physician's Printed Name, MD)

(Insert Physician's Phone Number)

** Clinicals are attached for supporting information **