

[Date]

[Payer Name]

[Payer Address]

Attn: [Appeals Department]

Re: [Patient Name]

[Policy ID/Group Number]

[Date of Service]

To whom it may concern:

My name is [name] and I am a [board-certified medical specialty] [NPI] writing on behalf of my patient, [patient name], to request coverage for [product, dosage, and frequency]. [Patient Name] has been under my care for [X] months for the treatment of [disease or symptoms].

I am writing this letter for medical necessity because, after working with [patient name], I believe that [product name] is the best treatment for this patient, and it's important that a formulary exception be made.

[Provide a brief medical history, including diagnosis, allergies, existing comorbidities, and International Classification of Diseases (ICD) code(s)].

[Discuss rationale for using <product name> vs other treatments. Insert your recommendation summary here, including your professional opinion of your patient's likely prognosis or disease progression without treatment.]

[List of pertinent medical records] are enclosed, which offer additional support for the formulary exception request for [product name]. Please consider coverage of [product name] for my patient.

Please contact me at [telephone number] to answer any pending questions. I would be pleased to speak to the medical necessity of [product name] for [patient's name]'s [diagnosis].

Thank you in advance for your attention to this request.

Sincerely,

[Physician name and signature]

[Physician's medical specialty]

[Physician's NPI]

[Physician's practice name]

[Phone #]

[Fax #]