CUT and PASTE: Template for a letter of Medical Necessity
The following Word document can be cut and pasted onto letterhead and used as a letter of medical necessity.

Date

Medical Director
Health Plan
Address
Fax:

Regarding:

Patient Name
Date of Birth
Insurance ID number
CPT Codes: 88230, 86352, 83520

Greetings:

I am writing to request that an exception be made to approve coverage of the tests performed by Moleculera Biosciences, Inc., for my patient [name of patient] who has the following diagnoses relevant to this request: [list diagnoses]

In addition to a request for an exception for coverage, I am requesting that the test be covered under the patient's IN-NETWORK benefits because Moleculera Bioscienes, Inc. is the sole provider of this test in the U.S.

This request is medically necessary for the following reasons: [choose one or more of the reasons]

I believe my patient's neuropsychiatric symptoms (INSERT SYMPTOMS) could be the result of an autoimmune response to an infection. Moleculera Biosciences offers a panel of tests known as the Autoimmune Brain Panel™ *(formerly known as the Cunningham Panel™)*, which could provide me with laboratory evidence supporting a clinical diagnosis of autoimmune encephalitis. This test could provide a differential diagnosis between an autoimmune condition (which causes neuropsychiatric symptoms such as those my patient is experiencing) and a primary psychiatric illness, which requires a completely different course of treatment.

Accurate and timely diagnosis will undoubtedly save the patient undue suffering and treatment delays. Understanding the etiology of the symptoms will likely prevent the expensive and potentially harmful trials of numerous psychotropic medications, as well as avoidable inpatient hospitalization. An expedient diagnosis will result in faster and much more cost-effective treatment which will benefit both the patient and you, their insurance carrier.

It will, or is reasonably expected to, prevent the worsening or continuation of an illness, condition, or disability. [Please provide details]

It will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, injury, or disability. [Please provide details]

It will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age. [Please provide details.]

Please let me know if you require additional information from my records.

Yours truly,

Additional letter writing tips: Be specific and include this information:

- Cite past successes with the treatment.
- Cite recent medical articles.
- Include letters from consultants including physical or occupational therapists
- Review previous and failed treatments.
- Address the HMO's suggested treatments.
- Be specific about psychological factors that are relevant to your chosen treatment.
- Provide information you have which a distant administrator may not know.
- Cite conversations with family members or other treating physicians.