Template for a Letter of Medical Necessity and Statement Form: The following content can be cut and pasted onto your practice's letterhead and used as a Letter of Medical Necessity. The Statement of Medical Necessity Form is attached for your use at your discretion.

Date

[Medical Director]
[Health Plan]
[Address]
[Fax]

Regarding:

[Patient Name]
[Date of Birth]
[Insurance ID number]

Dear [Insurance Provider]:

I am writing to request [insert product name] for my patient [name of patient] who I have diagnosed with Duchenne muscular dystrophy (DMD).

I've determined that this patient meets the indication for the product and therefore, this therapy is medically necessary.

In my clinical opinion, [insert patient name] should receive this therapy for the following reasons:

[List reasons]

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

Yours truly,

The following are some of the materials and information that may be requested by Payers in connection with the Statement of Medical Necessity Form:

- ☐ Chart notes
- ☐ Genetic tests
- ☐ Copy of the patient's insurance cards
- ☐ FDA Approval Letter
- ☐ Prescribing information
- ☐ Recent medical articles
- ☐ Letters from other specialists treating the patient such as cardiologists, pulmonologists and physical and occupational therapists
- ☐ Patient's psychological factors that are relevant to your chosen treatment
- ☐ Information to educate Medical Director or Pharmacy Director who is not familiar with the disease or treatment

Statement of Medical Necessity Form

Patient Information

First Name:		Last Name:	Middle Initial:	
Address:		City:	State:	ZIP:
Date of Birth:	Gender: ☐ Male ☐ Female	Height (in):	Weight (lbs):	
Primary Contact:				
Primary Phone:		Secondary Phone:	OK to leave messages? ☐ Yes ☐ No	

Insurance Information

Primary:	ID #:	Group #:	Phone:
Policy Holder:		Relationship to Patient:	
Secondary:	ID #:	Group #:	Phone:
Policy Holder:		Relationship to Patient:	

Diagnosis and Treatment Rationale

Diagnosis:	Date Diagnosed:
Method of Diagnosis:	ICD 10-CM:G71.0

Comments: _____

Site of Care Information ☐ Hospital Clinic ☐ Homecare ☐ Other

Site Name:		NPI #:		
Address:		City:	State:	ZIP:
Site Contact:	Phone:	Fax:	Email:	

Physician Information and Authorization

First Name:		Last Name:	State License #:	
Address:		City:	State:	ZIP:
Office Contact:	Phone:	Fax:	Email:	

_____ _____

Physician Signature Date