Durable Medical Equipment Medical Necessity Request

Date: [Insert Date]

Recipient Name: [Insert Recipient Name]

Recipient Title: [Insert Recipient Title]

Company/Insurance Name: [Insert Company/Insurance Name]

Address: [Insert Address]

City, State, Zip: [Insert City, State, Zip]

Patient Information

Patient Name: [Insert Patient Name]

Patient Date of Birth: [Insert Date of Birth]

Patient Insurance ID: [Insert Insurance ID]

Request for Durable Medical Equipment

We are writing to request prior authorization for the following durable medical equipment:

Equipment Name: [Insert Equipment Name]

HCPCS Code: [Insert HCPCS Code]

Frequency of Use: [Insert frequency of use]

Medical Necessity Justification

[Briefly explain the medical condition of the patient and why the requested equipment is necessary. Include relevant diagnosis codes and any prior treatments or equipment that have been tried.]

Supporting Documentation

Enclosed/attached are the following documents to support this request:

- Complete medical history and physical examination
- Recent treatment notes
- Test results
- Any additional relevant documentation

Conclusion

Thank you for your attention to this matter. Please do not hesitate to contact us if you need any additional information or clarification regarding this request.

Sincerely,

[Your Name]
[Your Title]
[Your Organization]
[Your Phone Number]
[Your Email]