Letter of Medical Necessity Template

1. Replace all red highlights with requested information in black.
2. Remove this heading.
3. Print final document on official practice/physician letterhead.

This is being provided solely for informational purposes and for your independent consideration and review. You should make any and all changes that you believe are appropriate, or disregard these suggestions in their entirety. Arthrex makes no assurances that the use of this letter will guarantee coverage or reimbursement of any item or service. The provider of services has the sole responsibility to determine medical necessity and to submit appropriate codes and charges for care provided in accordance with the particular payor(s)' requirements.

<Date>

<Contact Name>
<Title>
<Insurance Company Name>
<Insert Payer Address>

RE: Coverage and Reimbursement Request for surgical bone repair for the treatment of <injury>.
<Patient's Name>
<Patient's Date of Birth>
<Patient's Insurance Policy Information>

Dear <Contact Name>,

I am writing to request coverage benefits and reimbursement for <patient's first and last name>'s treatment for <injury>. I have evaluated and counseled this patient on various treatment options for their injury and find them a viable candidate for use of the demineralized bone matrix combined with platelet-rich plasma concentrate (cPRP) from bone marrow aspirate (BMA) for bone grafting and repair. This method provides the optimal scaffold for cPRP from BMA, which is a rich source of platelets and nucleated and progenitor cells. The following codes will be used for this procedure:

- CPT Code <include all CPT codes and code descriptions that will be used during the procedure>
- HCPCS Code <include all HCPCS codes and code descriptions that will be used during the procedure>

This patient suffers from <describe injury>. A copy of their most recent medical record is enclosed for your review. I believe my patient is an appropriate candidate for this procedure because:

Insert paragraph(s) regarding patient's pertinent medical history information to include:

- Duration of related symptoms
- Prior failed conservative treatments
- Impact on patient's quality of life
- Surgical risk factors such as age, obesity, or other health issues;
- Describe anticipated outcome without treatment and medical benefit of desired treatment base on clinical points supported in the literature

For this surgical procedure that I believe is medically necessary for this patient, I plan to use demineralized bone matrix combined with cPRP from BMA for bone grafting and repair. Please refer to enclosures for clinical efficacy details for this technique and procedure.

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I strongly believe that this surgical procedure to repair a bone void is medically necessary and warrants coverage based on the medical history of this patient as described above. I am enclosing documentation supporting the medical necessity of this treatment for this patient. I am requesting you provide coverage at this time. Please contact me at <requesting physician's direct telephone number> if you require additional information or would like to discuss the case in greater detail. Thank you for your timely response.

Sincerely,
<Physician's Name>
<Physician's Address>

Enclosures <Attach Supporting Literature>