Letter of medical necessity

To be completed by an attending physician

Patient information

Patient Name	*Parry Yap*
Date of Birth	*04/12/1985*
Policy number	*Insert policy number*
Group number	*Insert group number*
Medicare or Medicaid Number	*Insert number, if applicable*
Date of most recent evaluation	*mm/dd/yyyy*
Diagnosis	*Insert diagnosis e.g., gestational diabetes, pre-diabetes, high blood pressure, anxiety, etc.*
Treatment Recommendation	*Chiyo Program - postpartum program, hormonal balance & fertility program, prenatal program)*
Duration of Treatment	*Insert duration (e.g., length of pregnancy, 6 weeks, etc.)*

Letter of medical necessity

I am writing to request the [insert Chiyo Program] for my patient [first name, last name] who has the following diagnoses relevant to this request: [insert diagnostic description].

My patient [first name, last name] is [describe patient demographic information, patient condition, diagnosis, prior treatments - describe any previous failed treatments, if applicable]. I recommend the treatment of [insert Chiyo Program] in order to [treat, manage, or prevent] the medical condition of [insert medical condition]. This treatment is medically necessary to treat the specific medical condition described for the following reasons: [insert summary of examination, treatment recommendation and rationale - why is the treatment medically necessary].

This treatment recommendation will, or is reasonably expected to, aid in the management of the diagnosed condition. The treatment is not in any way for general health and is not for cosmetic purposes.

Best,

Physician Name (printed): _____

Physician Signature: _____

Date: _____

Phone Number: _____

Email: _____

Address: _____