

LETTER OF MEDICAL NECESSITY

DATE:

TO:

FROM:

PATIENT:

INSURANCE ID:

SUBSCRIBER:

DOB:

GROUP NO:

To Whom It May Concern:

XYZ is a _____ year old patient with a rare disorder (or inborn error of metabolism) called _____. This disorder is a type of _____ whereby the affected individual is unable to _____. The purpose of this letter is to explain the medical necessity of a treatment I am ordering for this patient which is imperative in the management of this condition. It is an amino acid supplement called _____.

The accepted standards of care to treat this disorder consist of a diet _____. Therefore, adequate protein intake and utilization may not be possible without the use of an amino acid supplement. Without adequate protein intake, the body _____ and this can cause _____. Without proper medical treatment, XYZ is at risk for _____ and other negative symptoms from his/her disease. This could lead to (hospital admissions, expensive diagnostic testing and critical consequences).

In XYZ's situation we have noted (_____ labs up/down, weight loss, feeding issues, behavioral issues, taste burnout with current metabolic supplement, inability to meet caloric needs, muscle wasting, fullness from certain formulas or those that must be taken in addition to food adding volume, other documented issues). This product is needed to assist in: (_____ meeting calorie needs, meeting overall protein needs, prevent vitamin/mineral deficiencies, reduce potential complications of this disorder, decrease need for medication/other treatments, prevent more expensive treatment options such as: _____). The use of prescription metabolic supplements has shown positive outcomes in evidenced-based research.

_____ is a powdered amino acid supplement that provides the necessary mixture of amino acids to meet XYZ's daily nutritional needs. It is manufactured by Vitaflo USA, LLC (1-888-VITAFLO). HCPCS is _____. Reimbursement code: _____.

The attached prescription is for XYZ to take _____ servings per day in order to meet his/her protein (and calorie) intake needs. This patient has already sampled this product and it has been tolerated and accepted well.

I appreciate your consideration with this request. Your authorization of the prescription will provide this patient the treatment needed to improve his/her medical situation, resulting in an overall cost savings to your company. Please feel free to contact me if you have additional questions.

Sincerely,
Name of Physician