Letter of Medical Necessity: Active Ice Cold Therapy System

Appeal / Preauthorization / Reimbursement Request

Today's date ____

Plan Name/Number __________________________________

Plan Address _______________________________________

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To whom it may concern:

This is a request for (choose one: appeal of your denial, pre-authorization, reimbursement) of a cooling vest for my patient, (patient name)______________, who lives with (type)________________. I prescribed this specialized system to help manage and/or relieve the patient of the various symptoms including; ____ ____.

(Patient name)_______________ has sought medical care due to chronic pain and symptoms on the following occasions: ____ ____ __.

After careful consideration of (patient's name)'s_______________ needs, functional capability and symptoms including (fill in specific details of relevant symptomatology and personal complaints), it is my conclusion that a cold water therapy system would assist in improving (patient's name)'s___________ overall quality of life as well as functional abilities.

I hope this information is helpful to you and others, and encourages you to think about the beneficial outcome for (patient's name)_____ by (choose one: reconsidering/authorizing) (him/her) as a recipient of a cooling garment.

I look forward to, and appreciate, your prompt response in this pressing matter.

Very Truly Yours,

(Physician name and signature)

(Physician contact information)

CC: (patient's name)

(patient contact information)