SAMPLE LETTER OF MEDICAL NECESSITY

[Date]
[Payer Name]
[Payer Address]
Attn: **[Medical Director]**

RE: [Patient Name]
[Policy number]
[Claim number, if applicable]

Dear **[Medical Director]**:

I am writing to provide additional information to support my claim for the treatment of **[Patient Name]** with **[Drug Name] [dosing]** for **[diagnosis code and description]**. I believe treatment of **[Patient Name]**, **DOB: [Patient DOB]** with **[Drug Name]** is medically appropriate and necessary and should be a covered and reimbursed service.

[Provide a description of patient's relevant medical history based on your clinical judgment]

Based on my patient's history, current medical condition, and the published data supporting use of **[Drug Name]**, it is my professional opinion that treatment of **[Patient Name]**, **DOB: [Patient DOB]** with **[Drug Name]** is medically appropriate and necessary.

Please call my office at **[telephone number]** if you require any additional information or documentation. I look forward to your timely response.

Sincerely,

[Physician Name]
[Telephone number]

Enclosures [to be determined by physician]

[This document is provided as a sample template that may be used to appeal a payer coverage decision. The physician is responsible for the content of the letter that is customized to include information concerning an individual patient.]

[The information contained in this template letter is provided by Pfizer for informational purposes for patients who have been prescribed a Pfizer medicine. There is no requirement that any patient or healthcare provider use any Pfizer product in exchange for this information, and this template letter is not meant to substitute for a prescriber's independent medical decision making.]