Medical Necessity

[Date of Submission]

[Health Plan Name]
[Health Plan Address]
[City, State Zip]

Re: [Insert Patient Name and Date of Birth]
Member ID#: [Insert Member ID Number]
Member Name: [Insert Member Name if not Patient]
Group Name: [Insert Group Name]
Group ID#: [Insert Group Number]

Dear Claims Department:

I am writing in support of payment by [Health Plan] for speech-language pathology services for [patient's name]. [Health Plan] denied payment for services because benefits cover only [insert coverage limitations]. *(See enclosed information from payer)* The [insert date of denial] letter of denial stated that [insert specific language from the denial letter]. Please let me take this opportunity to explain why [patient's name] speech-language pathology treatment should be covered.

[Patient's name] speech-language pathology services are medically necessary to evaluate and/or treat [insert diagnosis], a medical condition that [treating clinician's name], states in the enclosed report that [patient's name] [insert specific evidence from the clinical note to support this treatment.]

> **Below is an example of a statement to supports the argument coverage.**
> *[Health Plan's] coverage guidelines require a demonstration of previous speaking ability. This criterion is unreasonable when applied to infants and young children. Neurological damage caused [patient's name] speech-language impairment and benefits should be available, without the added requirement of demonstrating previous speaking ability for a child of such a young age that they cannot possibly comply. The denial also incorrectly indicates that [patient's name] speech-language needs are due to developmental delay and are considered educational in nature. [Patient's name] speech-language impairment is neurologically based and not a result of developmental delay nor educational in nature. [Patient's name] requires treatment for a medical condition.*

I respectfully request that you review the additional documentation provided and consider overturning your coverage decision regarding [insert specific language from the denial letter] for [patient's name]. Thank you for your prompt attention to this matter. I look forward to your

reconsideration. If I can provide any additional information, my contact information is provided below.

Sincerely,
[Treating clinician's name]
[Practice Name]
[Address]
[City, State Zip]
[Phone Number]
[Email]
[NPI]