Letter of Medical Necessity

DATE:

TO:

[Medical Director]

[Health Plan]

[Address]

[Fax: }

RE:

[Patient Name]

[Date of Birth]

[Insurance ID number]

Greetings:

I am writing to request [list quantity] RevoFit Lamination Kit and Adjustable Socket Design for my patient [name of patient] who has the following diagnoses relevant to this request: [list diagnoses]

This request is medically necessary for the following reasons:

[choose one or more of the reasons:]

* Manage Volume fluctuations
* Donning/Doffing assistance
* Controlling Rotation of the socket on the residual limb
* Secure the prosthesis on the residual limb
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The patient can adjust their prosthetic socket by twisting a dial that engages a lacing system that utilizes Spectralon™ lace and Teflon™ tubing to move areas socket.  The dial is inserted into a collar laminated into the socket.  The dial incorporates a gearing mechanism that reduces the force needed to create movement and advances the lace and moveable portions with precision accuracy; each “click of the dial” equal to 1 mm of movement.  The design and moveable areas are custom to each patient and their individual needs.

It will, or is reasonably expected to, prevent the onset of an illness, condition, or disability. [Please provide details:

1. The micro-adjustable tensioning device “RevoFit” is designed to control areas of a socket to provide both global and targeted areas to prevent motion within the prosthetic socket.
	* thereby reducing or eliminating sores and blisters caused by friction due to movement; i.e. levering, rotation, loose socket within the prosthetic socket.
	* reduce or rotation of the socket on the residual limb to prevent falling due to malalignment of the prosthetic foot and/or knee.
	* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

It will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, injury, or disability. [Please provide details]

1. The micro-adjustable tensioning device “RevoFit” is designed to open \_\_\_\_\_\_\_\_ area of the socket to provide unobstructed donning/doffing.  And then to fully and completely close the area to create a rigid socket frame.
* Bulbous Distal End
* Boney Prominence
* Weak or Limited hand/finger dexterity
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. The micro-adjustable tensioning device “RevoFit” is designed to tension over \_\_\_\_\_\_\_\_\_ area of the socket to secure the prosthetic socket to the residual limb.
* Bulbous Distal End
* Boney Prominence
* Unusual anatomy; i.e. PFFD
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

It will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, considering both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age. [Please provide details.]

Please let me know if you require additional information from my records.

Yours truly,

 **Additional letter writing tips: Be specific and include this information:**

* Cite past successes with the treatment.
* Cite recent medical articles.
* Include letters from consultants including physical or occupational therapists
* Review previous and failed treatments.
* Address the HMO's suggested treatments.
* Be specific about psychological factors that are relevant to your chosen treatment.
* Provide information you have which a distant administrator may not know.
* Cite conversations with family members or other treating physicians.

Incl:

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RevoFit™ Justification

MSRP