Letter of Medical Necessity

Date:

To: Insurer Name
Insurer Address
City / State / Zip Code

Re: Patient's Name: Patient's Name
Policy Number: Policy Number
Group Number: Group Number
Date of Birth: Date of Birth

To Whom It May Concern:

I am writing to notify you of my intent to treat Mr./Mrs. Patient Last Name with Apligraf®, which is a bilayered skin substitute used to treat diabetic foot/venous stasis ulcers. The patient's medical history is as follows:

Describe the patient's pertinent medical history. Include previous treatments, outcomes, and what therapy will be required if Apligraf treatment is not approved.

Apligraf was approved by the FDA for the treatment of venous stasis ulcers on May 22, 1998, and approved for the treatment of diabetic foot ulcers on June 20, 2000. Apligraf has been shown to heal more of these wounds faster than conventional therapy alone. I believe my patient will benefit from this therapy. Please feel free to contact me if additional information is required to process my request for coverage.

Sincerely,

Physician's Name