**[INSTRUCTIONS: PLEASE MODIFY TEXT IN RED ONLY. Delete the instructions, eliminate the italics and change the font from RED to BLACK. Add additional information as necessary.]**

Date: *(Insert today’s date)*

***(Insert Carrier name/address)***

**RE**: *(Insert patient name, ID or Medicare #)*

**In reference to:** *(Insert file number, appeal number or another reference identifier)*

**Dates of Service in Question:** *(Insert date or dates for the records attached)*

Attached you will find supporting documentation to substantiate medical necessity for the treatment provided by our office. Included in the packet of material is: *(Include all that apply)*

* A letter of medical necessity outlining the need for care
* Copies of office notes, exam findings, treatment plan(s), diagnosis, history form(s), Outcome Assessment Tools, X-ray findings, other diagnostic findings, discharge form
* Patient’s attestation of the need for care
* Reports and/or documentation from other healthcare providers for coordination of care during this episode
* Copy of the denial or EOB in question

In addition, you will find a summary of the important facts of the case that corroborate our request for appeal below.

|  |
| --- |
| **Beginning date of this episode of care or this burst of chronic care:** *(Insert date)*  **The visit(s) represent (s):** ( ) Acute Treatment ( ) Chronic Treatment  **The intake history/exam/ADL Deficits included:** *(Insert applicable information)*  **Subluxation demonstrated by:** *(Insert applicable information)*  **The Diagnosis codes assigned are as follows:** *(Complete as applicable)*  **Region 1: Region 2: Region 3:**  **Region 4: Region 5:**  **Treatment Plan included the following recommended care for these regions and anticipated tissue-specific responses:**  *(Insert applicable information)*  **The functional goals at the beginning of this episode were:**  *(Insert applicable information)*  **Total number of visits for this episode:**  *(Insert applicable information)*  **Number of visits for the date(s) in question as they relate to the stated episode:**  *(Insert applicable information)*  **Dates for follow-up examinations performed in this episode:**  *(Insert applicable information)*  **Patient compliance with treatment plan:**  *(Insert applicable information)*  **Patient discharge (or anticipated discharge) from this episode:**  *(Insert applicable information)*  **Treatment effectiveness demonstrated by:**  *(Insert applicable information)*  **Conclusion:**  *(Insert applicable information)* |

We hope this information clarifies our position that the visits in question are indeed medically necessary.

Please don’t hesitate to contact us if you have questions about this material. *(Insert name and signature of appealing doctor, team member, or entity)*