**Sample Letter of Medical Necessity**

[Date]

[Name of Health Insurance Company]

[Attn:]

[Address]

[City, State, Zip]

Re: Letter of Medical Necessity for Licart (diclofenac epolamine) topical system 1.3%

Patient: [Patient Name]

Group/policy Number: [Number]

Date(s) of service: [Dates]

Diagnosis: {Code & Description]

Dear [Insert contact name or department]:

I am writing on behalf of my patient, [PATIENT NAME], to document medical necessity for treatment with Licart.

Dosage and administration:

- Use the lowest effective dose for shortest duration consistent with individual patient treatment goals
- Do not apply to damaged or non-intact skin
- The recommended dose is one (1) LICART to the most painful area once daily

This letter serves to document that [PATIENT NAME] has a diagnosis of [DIAGNOSIS] and needs treatment with Licart and that Licart is medically necessary for [him/her] as prescribed. On behalf of the patient, I am requesting approval for use and subsequent payment for the treatment.

Patient Medical History and Diagnosis:

[PATIENT NAME] is a [AGE] year-old [MALE/FEMALE] diagnosed with [DIAGNOSIS]. [NAME OF PATIENT] has been in my care since [DATE]. As a result of [DIAGNOSIS], my patient [ENTER BRIEF DESCRIPTION OF PATIENT HISTORY].

Additionally, [PATIENT] has tried [PREVIOUS THERAPIES] and [OUTCOMES]. The attached medical records document [PATIENT NAME]'s clinical condition and medical necessity for treatment with Licart.