[Healthcare Provider’s Name]

[Clinic/Hospital Name]

[Address]

Phone: [Phone Number]

Fax: [Fax Number]

Date: [Insert Date]

## Letter of Medical Necessity

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Full Name], who is under my care for [diagnosed condition(s), e.g., arthritis, chronic back pain, inflammation, fibromyalgia, etc.].

As part of their treatment plan, I am recommending cryotherapy sessions to assist in the management of their symptoms. Cryotherapy is being prescribed to help reduce inflammation, relieve pain, and promote overall healing and mobility.

I recommend the following frequency and duration of treatment:
- [e.g., 2–3 sessions per week for 8 weeks]
- Re-evaluation will be conducted after the initial treatment period

This service is medically necessary and a part of the overall care plan to improve the patient’s condition and quality of life.

Please contact my office with any questions.

Sincerely,

[Signature]

[Printed Name, Credentials (e.g., MD, DO, DC, NP)]

NPI Number (if applicable): [Insert NPI]

License #: [Insert License Number]