**Letter of Medical Food Exclusion Removal**

Date:

Insurance Name:

Patient Name:

DOB:

Member ID:

Medical Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (ICD-10: \_\_\_\_\_\_\_\_\_)

CPT/HCPCS: B4157/B4162/B4153/B4155/B4104

**Re: Request for medical exclusion removal for medical foods and enteral formula.**

To whom it may concern:

We are requesting an exclusion removal for (patient name), (member ID#) from his/her/their contracted policy with (insurance name) for medical foods/enteral formula.

(Patient name), has been diagnosed with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(ICD-10: \_\_\_\_\_\_\_\_\_) that was detected at \_\_\_\_. Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and requires a dietary management to sustain (patient name) health capacity.

If \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is not treated properly or promptly it can lead\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, The primary treatment is a strict dietary control of the requested medical food (name of formula). (HCPCS Code\_\_\_\_\_\_\_\_\_\_\_\_) that is currently excluded on his/her/their plan. We are confident that (patient name) can avoid devastating consequences of untreated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ disease when he/she/they are provided the necessary medical food.

We are asking for your consideration to please remove the medical food exclusion for medical foods/Enteral Formula from (patient’s name) policy. The current exclusion indicates a non-coverage for medical foods, enteral formula, nutrients. The medical food (name of product) is a medically necessary that is consumed under strict medical supervision to ensure the health and well-being of my patient.

Please find attached the supported documentation for your review and consideration:

* Letter of Medical Necessity
* Clinical Notes/Prescription
* State mandate Law HB

If you have any question with this request, please contact me directly at (phone #). Thank you in advance for your consideration and review.

Sincerely, Sincerely,

(Physician’s Signature), MD (Dietitian signature), RD

(Physician’s Printed Name), MD (Dietitian’s Printed Name), RD

(Physician’s Phone Number) (Dietitian’s Phone Number)