MM DD, YYYY

Dear Medical Reviewer,

This is a letter of medical necessity for [Patient First and Last Name], [DOB mm/dd/yyyy]. This patient has been under my care, beginning [Month ##, YYYY] and is currently under my care and receiving pelvic physical therapy with the following procedure:

[List one or many of the following depending on preference. Delete this line and any unused lines.]

CPT Codes: Procedure [57400 or 58999]

OR

HCPCS Code: [E1399]

Using the following prescription purchase:

Supplies: 99070

In my medical opinion, it is necessary for her to perform vaginal dilation therapy. This patient sustained a [type of trauma or medical rationale here], which has resulted in pelvic floor dysfunction. She has the following diagnoses:

* [insert ICD-10 diagnoses code and diagnosis]
* [insert ICD-10 diagnoses code and diagnosis]

The patient was instructed to purchase vaginal dilators as necessary to her recovery.

She needs vaginal dilation therapy for the following reasons:

* [explanatory symptoms here.]
* [explanatory symptoms here.]

Please do not hesitate to reach out to me with further questions.

Sincerely,

[Insert signature here]

First Name Last Name, Credentials

TX #######

EIN ##-#######

NPI ##########