[Date]

RE: [PATIENT NAME, DOB, MEMBER ID NUMBER]

Medical Necessity Letter for Eating Disorder Medical Nutrition Therapy

Greetings:

I am writing this letter requesting that [NAME OF INSURANCE PLAN] reverse the improper denial of medically necessary Eating Disorder Medical Nutrition Therapy “MNT” (CPT 97803) for your insured, [PATIENT NAME]. They have been in my care for the treatment of [DIAGNOSIS AND ICD10 CODE] for [\_\_\_\_] months. Their treatment coverage has been wrongfully denied.

It is medically necessary that [PATIENT NAME] receives weekly Eating Disorder MNT for at least the rest of the year. Eating Disorder MNT is an essential standard of care treatment for eating disorders. If you are not familiar with Eating Disorder MNT or the standards of care for eating disorder treatment, I have attached additional supporting documents.

[SHORT SUMMARY OF PATIENT TREATMENT HISTORY - MENTION ANY OTHER LEVELS OF CARE/UNSUCCESSFUL ATTEMPTS AT SELF MANAGEMENT/ REDUCED FREQUENCY/ NEW STRESSES, ETC.]

Current focus of MNT for [NAME] is [NUTRITION DIAGNOSES/NUTRITION DEFICIENCIES/SIGNS & SYMPTOMS OF MALNUTRITION/ANY PHYSICAL HEALTH CONCERNS/ANY DIFFICULTIES EATING ADEQUATELY/COMPENSATORY BEHAVIORS/ETC.] Weekly Eating Disorder MNT is necessary because we must regularly monitor and adjust treatment strategies on an ongoing basis. One-time education is not adequate. As you know, continued outpatient treatment is an attempt to prevent a relapse or an expensive and disruptive hospitalization or higher level of care. There is no lower level of care.

Due to the complex nature of eating disorders, we must simultaneously address the psychological factors triggering the symptoms. Therefore MNT must continue together with psychotherapy. I have been in contact with [NAME’s] other providers and we are in agreement that continued and regular Eating Disorder MNT is medically necessary.

By way of background, [YOUR CREDENTIALS AND ANY EXPERIENCE WITH EATING DISORDERS, AND ANY REASON WHY THE PATIENT MUST SEE YOU, EVEN IF YOU ARE NOT IN-NETWORK WITH THE PLAN, SUCH AS THERE ARE NO OTHER EATING DISORDER SPECIALIST DIETITIANS IN YOUR AREA OR IN THEIR NETWORK].

Along with this request, I’m also asking for the following documents:

* The medical guidelines or criteria you’ll use to review this request
* The name, credentials, and specialty of the reviewer
* If the request is denied or limited, the notes or documents used to make that decision
* The comparative analysis for coverage of nutrition services and/or eating disorders, as required under federal parity law

Under HIPAA and the 21st Century Cures Act, these should be sent within 30 days.

Thank you for your anticipated cooperation in ensuring [PATIENT NAME] is approved for this medically necessary treatment and all previous claims are speedily paid. If you have additional questions you may contact me at [EMAIL] to set up a time to speak by phone.

Sincerely,

[YOUR NAME]