Letter of Medical Necessity

Your health care provider may fill out this Letter of Medical Necessity for services, treatments, or products that they feel are medially necessary for you or your eligible dependent(s).

Patient Information

Name

Date of Birth

Address

Phone Number

City, State, Zip

Insurance - Member ID #

Policyholder Name

Participant Employer

Medical Necessity Information

Medical Condition

Diagnosis Code

Recommended Treatment

Frequency/Duration of Treatment

Supplier Information

Katherine Miles CD, SBD, CYBE, ISE (New Moon LLC)

Name of Supplier

1508394305

NPI #

1736 N. Holland Ln.

Address

(316) 992-3901

Phone Number

Wichita, KS 67212

City, State, Zip

Physician Information

Name of Licensed Practitioner

NPI #

Address

Phone Number

City, State, Zip

I certify that this service, treatment, or product is medically necessary to treat the specific medical condition listed above, and is not in any way for general health or cosmetic purposes.

Signature of Licensed Practitioner

Date

PLEASE NOTE: Along with this letter, please attach a detailed receipt (including supplier name, date of service, services rendered or product purchased, and total price paid) when submitting your claim form.