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(No Cover Page Required)

**LETTER OF
MEDICAL NECESSITY**
take care®

Page 1 of _____

Patient Name: _____

Participant Name: _____

Participant's Employer: _____

Participant SSN: _____

This form should be completed by the attending physician to confirm treatment is necessary for a specific medical condition. Complete the following:

1. Describe the diagnosed medical condition being treated. (Include diagnosis code):

2. Describe the recommended treatment:

3. Indicate the duration of treatment:

This treatment is medically necessary to treat the specific medical condition described above. This treatment is not in any way for general health and is not for cosmetic purposes to improve appearance.

Signature of Attending Physician

Date

Print Name

Address: _____

Phone: _____
