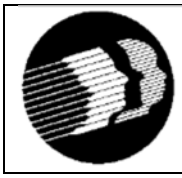

Practitioner's Medical Necessity Letter

11.0 Appendix D – Practitioner's Medical Necessity Letter

Practitioner's Medical Necessity Letter
STATE OF DELAWARE

Client's Name:_____Date of Birth:_____

Item Requested (separate letter required for each item requested):

_____

_____

1. Diagnosis and prognosis: Include present physical condition and functional limitations.

2. Treatment Plan. (Medications, therapies, nursing services, etc.)

3. Reason for use of requested item.

Estimated duration of use.

4. Expected Therapeutic effect of requested item.

5. Please attach pertinent laboratory/pulmonary function test results and/or summaries from other professionals involved in the care of this client.

Please note: Medicaid policy requires coverage of the least costly appropriate alternative available that can be safely and effectively provided to the client and not duplicate other services. The Medical Review Team may require additional information to process your request.

Physician's Name (Signature):_____Date:_____
Physician's Name (Printed)_____
Physician's Address:_____
_____
Physician's Phone Number:_____