

[Your Practice Name]

[Your Practice Address]

[City, State, Zip Code]

[Phone Number]

[Date]

[Insurance Company Name]

[Insurance Company Address]

[City, State, Zip Code]

Re: Patient Eligibility for Oxygen Therapy

Patient Name: [Patient's Full Name]

Patient ID: [Patient's ID Number]

Date of Birth: [Patient's Date of Birth]

Diagnosis: [Relevant Diagnosis]

Dear [Insurance Company Representative's Name or "To Whom It May Concern"],

I am writing to request approval for oxygen therapy for my patient, [Patient's Full Name], who has been under my care since [Date]. After a comprehensive evaluation and ongoing assessments, it has become clear that [he/she/they] requires supplemental oxygen to manage [his/her/their] medical condition effectively.

The medical necessity for oxygen therapy is substantiated by the following clinical findings:

- [Specify specific symptoms, test results, and any prior treatments]
- [Relevant laboratory or imaging studies]
- [Any other pertinent information]

Based on established criteria, [Patient's Name] qualifies for home oxygen therapy due to [specific eligibility criteria, such as arterial blood gas results, saturation levels, etc.]. I believe that this therapy is crucial in improving [his/her/their] quality of life and preventing further complications.

Please find attached the necessary documentation, including [list any attachments: medical records, test results, etc.].

Thank you for your attention to this matter. I look forward to your prompt response regarding this request.

Sincerely,

[Your Name]

[Your Title/Position]

[Your Medical License Number]

[Your Contact Information]