**SoftWave Sample Letter of Medical Necessity**

[Date]

[Insurance Company]

[Address]

[City, State, Zip Code]

Re: [Patient Name]

Policy Number: [xxxxxx]

Group Number [xxxxxx]

To Whom It May Concern:

Enclosed for your review are clinical articles documenting the effective use of [SoftWave’s DermaGold 100®].

The attached Statement of Medical Necessity and information pertaining to [Patient Name]’s clinical history and diagnosis clearly demonstrate that [SoftWave’s DermaGold 100®] is the appropriate treatment of choice.

Please send me written verification of coverage and payment for the procedure noted for [Patient Name] as soon as possible. If you have any questions pertaining to the clinical history or my treatment plan, please call me directly at: [Office Phone Number].

Thank you for your immediate attention to this matter.

Sincerely,

[Physician Name]

Enclosure: Statement of Medical Necessity

CC: Estimate of Professional and Facility Charges Patient Records

[Patient Name]

Medical Record File

[Facility billing contract]