Medical Necessity Letter Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · August 2026

A medical necessity letter (letter of medical necessity, LMN) is a clinician-authored narrative explaining why a specific service, level of care, or item is medically necessary for a particular patient. Therapists, psychologists, and psychiatrists send one to payers, FSA and HSA administrators, schools, and benefit programs to support coverage, reimbursement, or accommodations. Most run 1 to 3 pages; no law prescribes the format.

Recipient and reference block so the letter matches the request
Do: date, addressee, patient name and DOB, member ID, and the claim or authorization reference the letter supports.
Pitfall: no authorization or claim number; unmatched letters sit in a scanning queue while the decision clock runs out.

Credentials and treating relationship the evaluation behind the opinion
Do: your license and specialty, when treatment began, session count, current frequency, and the most recent visit date.
Pitfall: writing from a single visit; one-session letters are a recurring disciplinary trigger with boards and reviewers.

Diagnosis and functional impairment the code plus what it impairs
Do: the ICD-10-CM code and name, symptoms with measured scores, and impairment at work, school, home, or relationships.
Pitfall: the code alone; reviewers authorize against documented impairment, and a bare F33.2 gives them nothing to grant.

History and prior treatment stepped care, documented
Do: levels of care, therapy frequency, and medication trials with response, this episode and before.
Pitfall: omitting the less intensive alternatives that fell short; that is the first question in any level-of-care review.

The specific request units a reviewer can grant
Do: service or item, code if known, frequency, duration, re-evaluation point; FSA/HSA letters add condition treated and duration of need.
Pitfall: continued treatment with no units is not authorizable, and FSA administrators commonly cap validity at 12 months.

Clinical rationale the paragraph the format was built for
Do: why this intensity and duration fit generally accepted standards of care, and the deterioration expected without it.
Pitfall: arguing from credentials; coverage disputes turn on generally accepted standards of care, so anchor there.

Signature block verification beats stationery
Do: name, credentials, license number, NPI, direct contact, and date; supervisor co-signature where required.
Pitfall: chasing letterhead and ink; Medicare accepts e-signatures, while a missing license number or NPI stalls verification.

Before you sign

- [ ] Member ID, authorization reference, and request at the top
- [ ] Diagnosis paired with measured scores and named impairment
- [ ] Lower-intensity care dated, with response documented
- [ ] Request carries code, frequency, units, date range, re-evaluation
- [ ] Rationale argues generally accepted standards of care
- [ ] License number, NPI, and direct contact in the signature block

Drafting with AI

Bring the treatment plan, recent notes or a dictated summary, and the request with units; the order is fixed by convention: diagnosis, impairment, prior treatment, request, rationale.

> *"Draft a medical necessity letter to the plan's utilization review team: recurrent major depression, twice-weekly sessions, code 90837, 12 weeks then re-evaluation: …"*

Never paste patient-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

300 to 900 words	**20 to 45 min by hand**	**Authorization · appeals**	**Payers · FSA/HSA · schools**
one to three pages	clinical team estimate	plus FSA/HSA, school, program	who reads it

Full guide, sample letter, and compliance notes:
bastiongpt.com/template/medical-necessity-letter

BastionGPT drafts complete letters from your treatment plan and notes. Free 7-day trial.

Medical Necessity Letter Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Letterhead (practice name, address, phone, secure fax or portal):

Date: | To (plan / administrator / program): | Attn (utilization review / claims):

Re (patient name): | DOB: | Member ID:

Claim / authorization reference:

To the review team:

I am a _____ (license and specialty), and I have treated this patient since _____.

Sessions to date: | Current frequency: | Most recent visit:

This letter supports the request for _____.

Clinical rationale

ICD-10-CM code and name · symptoms with measured scores · impairment at work, school, home, or relationships · why this intensity and duration fit generally accepted standards of care · expected risk without it

Alternatives tried

Levels of care and treatments tried, with dates and response · what was tried at lower intensity and how it fell short

Specific request (service or item, code if known):

Frequency: | Duration / total units: | Re-evaluation date:

FSA / HSA letters: add the condition treated, a statement that the expense is not for general health or cosmetic purposes, and the duration of need.

I am available at _____ for questions or peer review.

Sincerely,

Signature: | Date:

Name, credentials, license #: | NPI:

Supervisor co-signature (if required): name, credentials, license #: