Speech Therapy Letter of Medical Necessity

[Current Date]

[Practice Street Address]

[City, State, Zip]

RE: [Patient Name]

To Whom It May Concern:

This letter serves to document the medical necessity for my client, [Patient/Client Name Here] to receive [list treatment/evaluation] for the treatment of [specific diagnosis]. Please find below specific details regarding [Name's] background, diagnosis, and the rationale for treatment.

Background: [Name] is a [#-year male/female] with a history of [speech-language/swallowing concern, diagnosis]. [Provide sufficient information for a non-therapist to understand the details of your patient/client's background. Include medical history if it is pertinant to any communication or swallowing difficulties].

Diagnosis: [Name] currently presents with the following difficulties related to [his/her] diagnosis of [diagnosis]: [Provide details about what the patient/client can and cannot do and how this affects their social/academic/behavioral progress and daily living. Include the date of onset if known. Describe the evaluation approach and date].

Treatment: [Name] requires intensive speech-language therapy to address the above concerns. [List specific treatment names or techniques and describe their history of effectiveness or how you expect the treatment to address the patient/client's needs. Describe the intended treatment plan (duration and frequency)] [If the patient/client has received treadment in the past, you may consider including how the patient responded to treatment and the rationale for continuing or changing the approach].

Thank you for your attention to this matter.

Respectfully,

[Your name, credentials]

[Practice name]