## Sample letter: Appealing on Behalf of Patient for Home Phototherapy

This letter is only an example.
Please edit this letter to suit your patient’s needs and replace **bolded** sections with the appropriate information. Remove this portion before submitting to your patient’s insurance company.

[**Today’s date**]

[**Name of Medical Director**]
[**Name of Insurance Company**]
[**Mailing address of Insurance Company**]
Re: [**Patient name**]
[**Member Identification number**]
[**Date of birth**]

Dear [**Name of Medical Director**],

I am contacting you on behalf of my patient, [**Patient name (insurance ID#)**], to request home phototherapy. [**Patient name**] is under my care for [**his/her**] [**psoriasis and/or psoriatic arthritis**] [**ICD code(s)**]. [**He/She**] has [**number**] percent of body surface area affected by psoriasis. [**Psoriasis is also involved in sensitive areas including face/genitals**]. [**Patient name**] started with [**treatment name/dose**] in [**year**]. [**Include any other treatments the patient has tried**]. Previous treatments have been unsuccessful due to [**list reasons**].

[**Explain how psoriasis affects patient’s personal or social life, work or ability to work, emotional well-being, or other aspects**].

[**Explain any comorbidities that patient has that is linked to psoriasis or psoriatic arthritis, such as heart disease, stroke, high blood pressure, diabetes, depression, or others**].

[**Patient name**] has received [**name of light therapy used**] with excellent response to this modality. In addition, **[he/she**] has an excellent response to natural UV sunlight. However, it is increasingly difficult for [**him/her**] to undergo outpatient phototherapy due to the frequency of prescribed treatments per week and the associated travel time.

I anticipate that this patient’s need for on-going treatment with [**name of light therapy used**] will be continuous due to the chronic nature of this disease and due to the fact that [**his/her**] psoriasis flares when this treatment is interrupted. Therefore, I feel that [**he/she**] is an excellent candidate for a home phototherapy unit. Allowing for this coverage will be more cost-effective over the long-term, as the continuation of light treatments in an outpatient setting will far exceed the initial cost of purchasing a home unit.

Although [**he/she**] may also be a potential candidate for alternative systemic therapies, I feel that home phototherapy would offer the safest, most convenient, and most cost-effective treatment option.

Please feel free to contact me, [**physician name**], at [**office phone number**] or [**patient’s name**] at [**patient phone number**] for any additional information you may require. We look forward to receiving your timely response and approval of this claim.

Sincerely,

[**Physician name and signature**]
[**Physician medical specialty**]
[**Physician NPI**]
[**Physician practice name**]
[**Physician office mailing address**]
[**Physician phone number**]
[**Physician fax number**]

[**Patient name and signature]**

Encl: Medical records
Supporting documentation
Photo(s)
Letter of Medical Necessity (LMN)

CC:   [**Name of patient**]