_____
Current Date

_____
Insurance Company Name

_____
Department

_____
Address 1

_____
Address 2

_____
City, State Zip Code

Re: _____
Patient Name

_____
Date of Birth

_____
Insurance ID Number

To Whom It May Concern:

I am writing on behalf of my patient, _____ to document the medical necessity of the Flyp Nebulizer (fn2000m) to administer _____ for the treatment of _____.
Patient Name
Medication
Diagnosis

This letter provides information about the patient's medical history and diagnosis and a statement summarizing my treatment rationale.

Patient's History and Diagnosis:

_____

_____
Include history of patient condition requiring the use of the Flyp pe1200m Portable Mesh Nebulizer, including the medical diagnosis and medication(s) being used to treat their condition.

Treatment Rationale:

_____

_____
Include information on the current and previous treatments up to this point, and why the Flyp Nebulizer (fn2000m) is necessary for your patient.

My patient has demonstrated a history of adherence with a standard compressor-based nebulizer system which has decreased mobility and activity levels, compromising quality of life. Flyp Nebulizer is a relatively low-cost device with promise to deliver outsized return on investment including greater participation in daily activity, a portable treatment option while traveling, and precise medication delivery as demonstrated in the device's aerosol characteristic testing results.

In summary, it is my belief that administering _____ with the Flyp Portable
Medication
Mesh Nebulizer is medically necessary for my patient's medical condition. I have evaluated a breadth of devices and have not identified a suitable substitute for the quality, portability, and ease of use of Flyp Nebulizer. Please contact me if any additional information is required to ensure the prompt approval of this treatment plan.

Sincerely,

_____
Provider Signature

_____
Provider Name

_____
Provider Phone