

Medical Necessity Letter

Reconstructive areola / nipple tattooing

Practice / physician letterhead details (name, address, phone, fax)

Date

To: Insurance company / utilization review

Re: Patient name

Date of birth

Member / policy ID

Dear Medical Review Team:

I am the treating physician for the patient named above. I request consideration of coverage / authorization for reconstructive areola and/or nipple tattooing (micropigmentation), based on my evaluation and the patient-specific findings below.

Diagnosis and applicable ICD-10-CM code(s)

Relevant surgery / reconstruction: type(s), date(s), and right, left, or bilateral side(s)

Current clinical findings: nipple / areola loss, pigment changes, asymmetry, or other findings

In my clinical judgment, this service is medically necessary as part of this patient's reconstruction for the following individualized reasons:

Clinical rationale, reconstructive goals, and supporting evidence / records

Healing / readiness assessment, timing, and any precautions or restrictions

Requested CPT code(s) / units (biller to confirm)

Treatment area (sq cm) / side(s)

Planned artist: Michelle Brantley-Machuca, SeaChelle's, LLC, 623 N Lime Avenue, Sarasota, FL 34237. Phone: (941) 348-1933 | Email: Seachellespm@aol.com.

Please review this request with the supporting records. Contact my office for further information.

Physician name / credentials

NPI

Physician signature: _____ Date: _____

Physician use: personalize and sign only if clinically supported; attach relevant records and use practice letterhead if required. CPT references: 11920 (up to 6.0 sq cm), 11921 (6.1-20.0 sq cm), +11922 (each additional 20.0 sq cm or part thereof). Confirm coding, provider eligibility, and payer rules. This letter does not guarantee payment.