YOUR LOGO

**Date**
**Clinic Name**
**Clinic Address**
**Clinic Address**

**RE: Patient Name**
**Date of Birth:**
**Policy ID/Group number:**
**Policy Holder:**

I am writing on behalf of my patient, (insert patient name), to document the medical necessity of Food Sensitivity and Nutritional Counseling Therapy.

On (insert day), I examined (insert patient name) and determined the patient had a need of the following; need to improve exercise performance, need to balance of metabolism, need to reduce inflammation, stimulate fat burning, increase energy, support anti-aging……list out the rest

I then suggested ((insert patient name) proceed with the Food Sensitivity and Nutritional Counseling Therapy. The treatment consists of ……
The key to the treatment is repetitive ongoing counseling until the patient is comfortable, compliant, and health benefits become evident.

In summary, Food Sensitivity Testing and Nutritional Counseling Therapy is necessary and reasonable for (insert patient name)'s medical condition. Please contact me if any additional information is required to ensure the prompt approval of this course of therapy.

Sincerely,

Providers Name
Providers Phone Number