**Sample EPSDT Letter of Medical Necessity**

***Provided by Josh Norris, Director of Legal Services, Georgia Advocacy Office***

[***www.thegao.org***](http://www.thegao.org)

RE: [Name of child]

DOB:

Dear \_\_\_\_\_\_\_\_\_\_\_\_\_,

I have assessed the above-named child. I am a [physician, nurse, psychologist, clinical social worker, occupational therapist, etc.] licensed to practice in the State of Georgia. I have determined based upon my training and experience that this child requires [list the treatments, procedures, therapies or tests you believe the child needs based upon your assessment]. I am making this request pursuant to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provisions of the Medicaid Act**,** 42 U.S.C.A. § 1396d(r).

(Include the following information:

1. All diagnoses
2. All prognoses
3. Service being prescribed as medically necessary
4. Amount, scope and duration of service being prescribed. For example: I am prescribing 4 hours of PT each week for the next 90 days at which time I will re-evaluate the child’s condition to determine if the services are still necessary)

[Describe the child’s medical history, and current diagnoses and treatments. Describe the treatment that you are requesting/prescribing and a description of how this treatment will “correct or ameliorate” any physical or mental illness or condition of the child.]

If you deny this request, please provide prompt written notice to this office [and the child’s parent or legal guardian] of the reason for the denial and the process by which your decision may be appealed.

Sincerely,