



# Northwood

## LETTER OF MEDICAL NECESSITY

Claimant Name: \_\_\_\_\_

Claimant DOB: \_\_\_\_\_

Type of Insurance: \_\_\_\_\_

Claim #: \_\_\_\_\_

This form should be completed by the prescribing physician to confirm that the prescribed item(s) are related to the motor vehicle accident that occurred on \_\_\_\_\_.

Please complete “yes” or “no” for the following prescribed item(s):

**Item being prescribed:** \_\_\_\_\_ **Duration of need:** \_\_\_\_\_

**Related to MVA:**

Yes - Please describe how the prescribed service is related to the MVA and the related diagnosis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

No – The prescribed service is not related to the MVA.

Comments: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*Signature of Prescribing Physician* / *Date*

Physician Name (print): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

**Please call 1-800-393-6432 with any questions or concerns**  
**Please complete the form and fax to:**  
**Northwood Auto No-Fault/PIP Program (586) 757-3457**  
**Attn: \_\_\_\_\_**