

Letter of Medical Necessity

To: Whom It May Concern

From:

**Re: Requesting coverage approval for the EarPopper Device
NDC # 08564-0000-00**

Patient/Beneficiary:

DOB:

Dx:

ICD-9:

CPT Code with Definition:

To Whom It May Concern:

The purpose of this letter is threefold: **First and foremost** to obtain financial insurance coverage on the **EarPopper** for patient: _____. **Second**, provide pertinent background information on the medical status of my patient. **Third**, provide important key information on the critical features of the requested medical device.

The patient is _____ years old and has been diagnosed with:_____.

I have prescribed the EarPopper device for the treatment of said condition.

The EarPopper is a safe, simple, medical device used to open the Eustachian tube and ventilate the middle ear. This device is a non-invasive, non-drug related option to treat Otitis Media with Effusion, Eustachian Tube Dysfunction and other issues related to middle ear pressure. The EarPopper is designed to provide instant relief from pressure buildup, restore hearing and drain fluid from the middle ear with daily use. The device treats patients who suffer from common ear problems caused by colds, allergies, sinusitis, rhinitis and elevation changes.

Due to the rising cost of repeated physician office visits for persistent ear problems, the EarPopper is a proven method of treatment which will offer your health plan a substantial **COST SAVINGS**.

With the EarPopper being utilized in the home setting for continued relief of ear pressure, my patient will be able to self administer ear pressure relief as well as provide a savings to your health plan by helping reduce the costs involved with return office visits, pharmacy costs associated with medication/antibiotics and hospital costs associated with myringotomy surgery. The reason for continued home use is based on clinical evidence associated with Eustachian tube inflation with the latest study published in the peer review journal – ENT Journal. This study demonstrated the safety and efficacy of the EarPopper device when used at home for an extended period.

I, respectfully request that the EarPopper device be a covered item within the guidelines of your health plan.

Thank you,

Signature _____

Date _____