Date_____

Re: Patient_____ ID #_____

DOB _____ Group # _____

Dear Medical Director:

This is a letter of medical necessity for the DPL™ Therapy System from LED Technologies, LLC. The DPL™ Therapy System is being prescribed for the relaxation of muscles and relief of muscle spasms; temporary relief of minor muscle and joint aches, pains, and stiffness; temporary relief of minor pain and stiffness associated with arthritis; and to temporarily increase local blood circulation.

Mr./Mrs. _____ is a _____ year old ____ Male ___ Female who has a diagnosis of _____ caused by _____.

The patient experiences chronic intractable pain that has/have not resolved with other interventions and which is adversely affecting his or her quality of life. The following interventions have already been tried without success:

_____
_____
_____
_____
_____

The patient's condition is exacerbated by:

___ Wounds ____ Peripheral Vascular Disease ____ Ischemia

Other _____.

The DPL™ Therapy System is a recognized treatment that works by increasing circulation to the affected areas through photobiomodulation. Several studies have been published in peer reviewed journals on its use in reducing pain, healing chronic wounds and restoring protective sensation.

I believe that Mr./Mrs. _____'s condition will benefit from the use of the DPL™ Therapy system at home because this patient has already responded to treatment in a clinical setting. As a result of this treatment in my care, the patient has shown significant improvement in pain, quality of life improvements and reduction in pain and/or sleeping medications. This modality of treatment is cost-effective and appropriate in this instance, since the patient's symptoms have not improved with other interventions. Since this device may be used at home, the patient will better able to comply with the treatment regimen. The patient will remain in my care while using this device.

Please feel free to contact me at _____, phone # _____ if you have any questions.

Sincerely,