Reel Free
Breathe Easy, Move Freely®

Letter of Medical Necessity

Full Name: _____
Date of Birth (MM/DD/YYYY): _____
Diagnosis/Condition: _____
ICD-10 Diagnosis Code (if known): _____
Patient Address: _____
City: _____ State: _____ ZIP: _____

Subject: Statement of Medical Necessity For: Buddy™ Oxygen Tubing Reel

Dear Authorization Reviewer,

This letter is to certify that the patient named above is currently undergoing physician-prescribed supplemental oxygen therapy for a diagnosed respiratory condition (such as COPD, pulmonary fibrosis, emphysema, or a related disorder).

As part of their home treatment plan, I am recommending the use of the **Buddy™ Oxygen Tubing Reel**, a Class I medical device that may support the delivery of oxygen by helping to manage and organize oxygen tubing during use. The device is designed to keep tubing from becoming tangled or obstructed, which may aid in maintaining more consistent oxygen flow and ease of use in daily living.

For individuals using oxygen throughout the day, tubing management can be a source of inconvenience or difficulty. The use of this device may contribute to a more comfortable experience with oxygen therapy and may help the patient better manage their prescribed treatment.

In my professional opinion, the Buddy™ Oxygen Tubing Reel is **medically necessary** to support this patient's ongoing oxygen therapy regimen.

Sincerely,

Physician Full Name: _____
Practice or Facility Name: _____
Phone Number: _____
Email Address: _____
Office Address: _____
City: _____ State: _____ ZIP: _____
National Provider Identifier (NPI): _____
Medical License Number (if applicable): _____