

EXAMPLE LETTER ONLY

Date:
Plan name:
Address:
City, State, Zip:
Patient/Insured Name:
Patient ID:
Policy number:
Group number:
Date of treatment:
Prior treatment date:

To whom it may concern,

(Patient name) was seen in my office today for (his/her) routine exam including (periodontal examination for new patient or maintenance appointment for existing patient). (Patient name here) presented to my office on (date) and received a periodontal exam that included periodontal probing. Upon examination, periodontal pockets sites were found of 5 mm or greater and had localized bleeding when probed. Treatment initiated included scaling and root planing and oral hygiene instruction.

Based on the patient's clinical presentation, I placed ATRIDOX® (doxycycline hyclate) 10% in each of the pockets listed below:

Tooth #	Site Treated (MB B DB ML L DL)	Probed Pocket Depth	Total Treated Areas by Tooth

The objective of this course of therapy is to halt the progression of the periodontal disease and reduce the probability of further destruction of the periodontium. ATRIDOX® is clinically proven and indicated for use in the treatment of chronic adult periodontitis for gain in clinical attachment, reduction in probing depth and reduction in bleeding on probing.

I have attached the following documents relating to this treatment and the patient's history: Patient periodontal chart, patient radiographs, ATRIDOX® full prescribing information and insurance claim form.

I certify that this information is correct. Please contact me should you have questions regarding the attached claim submission.

Sincerely,

(Dr. name)
(Practice name)
(State license #)

Enclosures:
Insurance claim
Patient periodontal chart
Patient radiographs
ATRIDOX® full prescribing information