(Sample letter of medical necessity is intended to be used on the prescribing physician's letterhead.)

Current Date

Patient Name:
Participant/Employee Name:
Employer:

Health Care Provider Name:
Health Care Provider Telephone Contact:

Diagnosed Medical Condition:

Recommended Treatment: Zimmer Biomet's mymobility® with Apple Watch®

Duration: (Start Date to End Date of Episode of Care)

Description of Recommended Treatment:

I am requesting approval of the Zimmer Biomet mymobility® with Apple Watch® as an approved medical expense needed for the treatment of the above named patient's (diagnosed medical condition). mymobility with Apple Watch is an important piece of the patient's treatment protocol. Incorporation will contribute to successful surgical preparation and recovery.

mymobility is a digital care management system that uses the Apple Watch to deliver support and guidance to my patient while collecting and delivering patient data to me regarding their treatment so I can monitor their recovery.

The app provides my patient with a constant connection to myself and their care team.
Key pieces of information transmitted and available through mymobility via the Apple Watch platform to my patient regarding their (diagnosed medical condition) are:

- Information to ensure the patient understands their condition prior to surgery
- Information to educate the patient on what to expect the day of surgery
- Details on how the patient can help minimize complications after surgery
- Pain management tracking that sets expectations about the patient's pain and healing and provides them with the ability to communicate their level of pain
- Guidance as the patient works toward regaining mobility
- Personalized rehabilitation exercise programs
- Telemedicine video visits for efficient and convenient care
- Activity metrics (such as gait speed and number of steps taken) and assessments tracking their recovery

The expense would not have been incurred if not for the patient's (diagnosed medical condition) and as such should be deemed an approved and reimbursable medical expense.

I certify that this service or product is medically necessary to treat the specific medical condition described above and is not in any way for general health or for cosmetic purposes.

Name of Provider:

Signature:

Date:

This document contains personal health information. If you are not the appropriate recipient of this information, please notify the healthcare provider listed above.