Patient Name: _____
Date of Birth: _____
Subscriber/Member ID: _____

To Whom It May Concern:

This letter is to provide medical documentation supporting the necessity of a sinus lift procedure (CDT D7951 – Sinus Augmentation via Lateral Open Approach) performed on [Insert Date] for the patient listed above.

The patient required this procedure due to insufficient vertical bone height in the posterior maxilla, making it impossible to place a dental implant without additional bone augmentation. Diagnostic imaging, including CBCT and/or periapical radiographs, clearly demonstrates maxillary sinus pneumatization in the area designated for implant placement. As a result, the existing bone volume was inadequate to achieve proper implant stability and osseointegration.

The sinus lift was medically necessary to restore bone height and provide a stable foundation for future implant placement at site #_____. This procedure directly supports the patient's ability to chew effectively, maintain adequate nutrition, and restore normal oral function. Without this augmentation, implant placement would be contraindicated, resulting in compromised oral health and reduced masticatory function.

We respectfully request consideration for dental benefit coverage of this essential treatment. Supporting clinical documentation, radiographic images, and the treatment plan are enclosed.

Sincerely,

[Doctor's Name]
[Practice Name]
[Contact Information]