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 periodon-tal chart, patient radiographs, ATRIDOX® full prescribing information and insurance claim form.

I certify that this is 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