Dear Health Legislative Assistant,

My name is _____. I am one of your constituents, and I live in _____.

Please cosponsor **H.R. 3332,** which provides coverage for wigs as durable medical equipment under the Medicare Program. This legislation is important to me and many people in your district and across the country who are affected by alopecia areata and other medically related hair loss conditions.

HR 3332 will grant increased access to cranial prosthetics and therapies for patients with alopecia areata and other forms of medical hair loss. Many patients living with medical hair loss suffer from a variety of diseases, including cancer. With no known cause or cure, alopecia areata is an autoimmune skin disease affecting approximately 6.8 million Americans, many of whom are children.

Alopecia areata usually starts with one or more small, round, smooth patches on the head and can progress to total scalp hair loss (alopecia totalis) or complete body hair loss (alopecia universalis). This common skin disease is highly unpredictable and cyclical. Hair can grow back in or fall out again at any time, and the disease course is different for each person.

Many individuals affected by alopecia areata utilize cranial prosthetics (or wigs) as there are currently few effective treatment options. Unfortunately, these prosthetics can come with a significant out-of-pocket cost for Americans with low or fixed incomes. This is especially burdensome for children, who often require cranial prosthetics for attending school.

For more information on the bill or to become a cosponsor of H.R. 3332, please contact Saundrea Shropshire in Congressman McGovern's office (Saundrea.Shropshire@mail.house.gov or 5-6101) or Chad Michaels in Congressman Schweikert's office (Chad.Michaels@mail.house.gov or 5-2190). Thank you for your consideration of my request.

Sincerely,

Constituent Name (signature)

_____
                                        Required

Constituent Name (printed)

_____
                                        Required

Street Address/P.O. Box

_____

City _____**State** _____ **ZIP** _____
              Required   *required*   *required (+4, if known)*

Date _____

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