Date: [Insert Date]

To: [Insurance Company Name]
Attn: [Appeals/Authorization Department]
Fax/Address: [Insert Fax Number or Address]

RE: Letter of Medical Necessity for In-Home Neurological Rehabilitation Nursing

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insert ID Number]
Group Number: [Insert Group Number]
Policy Holder: [Name of Policy Holder]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to formally request authorization for skilled in-home nursing services for neurological rehabilitation. [Patient Name] is currently under my care for the treatment of [Primary Diagnosis/ICD-10 Code] following a [Date of Incident, e.g., Stroke, Traumatic Brain Injury, Spinal Cord Injury].

Clinical Summary:
The patient presents with significant neurological deficits, including [List symptoms, e.g., hemiparesis, cognitive impairment, dysphagia, or neurogenic bladder]. Due to these complexities, the patient requires a level of care that exceeds the capabilities of unskilled caregivers.

Medical Necessity:
In-home skilled nursing is medically necessary for the following reasons:

- **Medication Management:** Administration and monitoring of complex neurological medications, including [List specific meds if applicable].
- **Safety Monitoring:** High risk for [Seizures/Falls/Aspiration] requiring professional intervention.
- **Rehabilitative Support:** Integration of neuro-rehabilitation protocols to prevent secondary complications such as contractures or pressure ulcers.
- **Assessment:** Frequent neurological checks and vitals monitoring to track progress or identify acute decline.

Proposed Treatment Plan:
I am prescribing skilled nursing care for [Number] hours per day, [Number] days per week, for a duration of [Number] months. The goal is to stabilize the patient's condition and facilitate the transition to a lower level of care as functional independence improves.

Failure to provide these services will significantly increase the risk of hospital readmission and permanent disability. Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Practice Name]