

**Date:** [Insert Date]

**To:** [Insurance Company Name / Review Board]

**Recipient Fax/Address:** [Insert Address/Fax Number]

**Subject:** Letter of Medical Necessity for Specialized Pediatric Stroller

**Patient Name:** [Patient Name]

**Date of Birth:** [Patient DOB]

**Policy Number:** [Insurance ID Number]

**Group Number:** [Group Number]

To Whom It May Concern,

I am writing to formally request coverage for a specialized pediatric adaptive stroller (HCPCS code: [Insert Code, e.g., E1236]) for my patient, [Patient Name]. [Patient Name] is currently under my care for the treatment of Cerebral Palsy (ICD-10: [Insert Code, e.g., G80.9]).

**Clinical Diagnosis and Functional Status:**

The patient presents with [mention specific symptoms, e.g., hypertonia, poor trunk control, inability to ambulate independently]. Due to the severity of their Cerebral Palsy, the patient lacks the postural stability and muscle tone required to utilize a standard commercial stroller or to walk functional distances safely. Currently, the patient requires maximum assistance for mobility.

**Medical Necessity:**

A specialized pediatric stroller is medically necessary for this patient to:

- Provide essential pelvic and trunk support to prevent skeletal deformities and skin breakdown.
- Maintain an upright, neutral position to assist with respiratory function and safe swallowing.
- Allow for safe transport to medical appointments and therapy sessions.
- Accommodate [mention specific features needed, e.g., tilt-in-space, adjustable recline] which are required to manage the patient's [mention condition, e.g., fatigue or reflux].

**Equipment Recommendation:**

I am prescribing the [Insert Specific Model/Brand Name]. This specific model was chosen because it provides [Insert specific feature, e.g., lateral supports and five-point harness] that are not available in standard consumer-grade strollers. A standard stroller does not provide the orthopedic support necessary for this patient's diagnosis and would put the patient at risk for injury or physical regression.

In summary, the [Insert Model Name] is an essential component of this patient's medical treatment plan. It is not for convenience, but is a medical requirement for safe positioning and mobility.

Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Clinic/Hospital Name]