

**Date:** [Date]  
**To:** [Insurance Provider Name]  
**Attention:** Medical Review Department

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

**Patient Name:** [Patient Name]  
**Date of Birth:** [DOB]  
**Policy Number:** [Policy Number]  
**Group Number:** [Group Number]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to formally request coverage for a specialized pediatric adaptive stroller. [Patient Name] is currently under my care at [Clinic Name] for the treatment of [Primary Diagnosis, e.g., Cerebral Palsy, Spina Bifida, Muscular Dystrophy] (ICD-10: [Code]).

**Clinical Status:**

The patient presents with significant physical impairments, including [List Symptoms, e.g., severe hypotonia, lack of trunk control, inability to ambulate, and poor head control]. Due to these limitations, the patient is unable to utilize a standard commercially available stroller or maintain an upright seated position without specialized postural support.

**Medical Necessity:**

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

- Provide essential spinal alignment and pelvic stability to prevent progressive skeletal deformities (e.g., scoliosis).
- Accommodate [Specific Needs, e.g., tilt-in-space or recline functions] to manage pressure distribution and prevent skin breakdown.
- Ensure safe transportation for medical appointments and daily activities where a standard wheelchair is not yet developmentally appropriate.
- Support respiratory and digestive function by maintaining an optimized seated posture.

**Equipment Recommendation:**

I am prescribing the [Model Name/Type of Stroller] with the following necessary modifications: [List Accessories, e.g., lateral trunk supports, headrest, Five-point harness].

In summary, [Patient Name] requires this specialized equipment for basic mobility and to maintain physiological health. Without this device, the patient is at high risk for secondary complications and further functional decline. Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Physician Signature]

**[Physician Name, MD/DO]**

[NPI Number]

[Clinic Name]