

**Date:** [Date]  
**To:** [Insurance Company Name]  
**Attention:** Medical Review Department  
**Fax/Address:** [Fax Number or Address]

**RE:** [Patient Full Name]  
**Date of Birth:** [Patient DOB]  
**Policy Number:** [Policy Number]  
**Group Number:** [Group Number]  
**Diagnosis:** [Diagnosis Codes, e.g., ICD-10 G80.9, G40.90]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to formally request coverage for a specialized adaptive pediatric stroller ([Specific Make/Model, if known]). [Patient Name] is currently under my care in the Neurology Department for the treatment of [Primary Diagnosis, e.g., Cerebral Palsy, Spinal Muscular Atrophy, or Refractory Epilepsy].

Due to the patient's neurological condition, they present with the following functional limitations:

- [List limitation: e.g., Global developmental delay and inability to ambulate independently]
- [List limitation: e.g., Poor trunk control and inability to maintain an upright seated position]
- [List limitation: e.g., Risk of injury due to frequent seizures or high muscle tone]
- [List limitation: e.g., Fatigue and respiratory compromise when using standard seating]

A standard, commercially available stroller does not provide the necessary postural support or durability required for this patient's medical needs. The requested specialized stroller is medically necessary for the following reasons:

- **Postural Support:** Features such as lateral trunk supports and a contoured seating system are required to prevent skeletal deformities and skin breakdown.
- **Positioning:** The tilt-in-space/recline feature is essential for pressure relief, managing autonomic dysfunction, and maintaining an open airway.
- **Safety:** A specialized five-point harness and reinforced frame are necessary to transport the patient safely during [seizure activity/spasticity episodes].

Without this equipment, [Patient Name] is at high risk for secondary complications, including hip subluxation, scoliosis, and decreased pulmonary function. This stroller is the least costly alternative that meets the patient's complex neurological and orthopedic needs for daily positioning and safe transport to medical appointments.

I strongly recommend the approval of this equipment. Please contact my office at [Phone Number] should you require additional clinical documentation.

Sincerely,

[Physician Signature]

[Physician Printed Name], MD/DO

Department of Neurology

[Facility Name]

[NPI Number]