Date: [Date]
To: [Insurance Company Name]
Attention: Utilization Review/Medical Review Department
Address: [Insurance Company Address]

RE: Letter of Medical Necessity for Specialized Pediatric Stroller
Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
ICD-10 Code(s): [Diagnosis Codes]

To Whom It May Concern,

This letter is written on behalf of [Patient Name] to request the authorization and purchase of a specialized pediatric stroller ([Brand/Model Name]). [Patient Name] is currently under my care for Physical Therapy due to [Primary Diagnosis].

Clinical Presentation:
The patient presents with [List symptoms, e.g., significant hypotonia, lack of trunk control, inability to ambulate independently]. Due to these physical limitations, the patient is unable to safely use a standard commercial stroller or maintain an upright seated position without specialized postural support.

Medical Necessity:
The requested specialized stroller is medically necessary to provide:
- **Postural Support:** [Explain need for lateral supports, headrest, or pelvic positioning].
- **Safety:** [Explain risk of falling or injury in standard equipment].
- **Pressure Management:** [Explain need for specialized seating to prevent skin breakdown].
- **Transportation:** To allow the patient to be safely transported to medical appointments and therapy sessions.

Equipment Recommendation:
Based on my clinical evaluation, I recommend the following equipment and accessories:
- [Item 1: Base Frame]
- [Item 2: Specific Support Accessory]
- [Item 3: Specific Support Accessory]

Alternative Equipment:
Standard strollers were considered but ruled out because they do not provide the necessary [tilt-in-space/trunk support/durability] required for this patient's specific medical needs. A standard wheelchair is not appropriate at this time because [Reason, e.g., patient is too small/requires portable folding frame].

In summary, this specialized stroller is essential for the patient's health, safety, and functional mobility. Please contact me at [Phone Number] if you require further clinical documentation.

Sincerely,

[Signature]
[PT Name], PT, DPT
[Clinic Name]
[License Number]
[NPI Number]