

**Date:** [Insert Date]

**To:** [Insurance Company Name]

**Attention:** [Prior Authorization Department]

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

**RE: Letter of Medical Necessity for Heavy-Duty Specialized Pediatric Stroller**

**Patient Name:** [Patient Name]

**Date of Birth:** [DOB]

**Member ID:** [ID Number]

**Diagnosis/ICD-10 Codes:** [Insert Diagnosis Codes, e.g., G80.9, Q05.9]

To Whom It May Concern,

I am writing to formally request the authorization and coverage for a heavy-duty specialized pediatric stroller for my patient, [Patient Name]. I have been treating this patient since [Year] for [Primary Diagnosis].

**Clinical Status:**

[Patient Name] presents with [describe physical limitations, e.g., significant muscle spasticity, inability to ambulate independently, poor trunk control, and fatigue]. Due to the patient's current height of [X inches] and weight of [X lbs], standard pediatric strollers are no longer safe or structurally sufficient to support their postural needs.

**Medical Necessity:**

A heavy-duty specialized stroller is medically necessary for this patient for the following reasons:

- **Postural Support:** The patient requires specialized seating interventions to prevent skeletal deformities and maintain respiratory function.
- **Safety and Durability:** Due to [Weight/Extensor Thrusting/Involuntary Movements], a reinforced heavy-duty frame is required to ensure the device does not collapse or tip during use.
- **Mobility for Medical Appointments:** The patient is unable to walk long distances or sit in a standard wheelchair for extended periods. This device allows for safe transport to medical therapy and specialist appointments.
- **Skin Integrity:** The specialized pressure-relieving materials in this stroller are necessary to prevent skin breakdown and pressure sores.

**Equipment Requested:**

[Insert Specific Model Name, e.g., Convaid Cruiser or Liberty FT] with the following modifications: [Insert specific accessories like lateral supports, headrest, or heavy-duty wheels].

**Clinical Outlook:**

Without this equipment, [Patient Name] is at high risk for [falls, skin breakdown, worsening

scoliosis, or social isolation]. A standard wheelchair is not appropriate at this time because [explain why, e.g., the patient requires the portability or tilt-in-space features of a stroller].

I certify that the above-requested equipment is medically necessary and is the least costly alternative to meet the patient's specific functional needs.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[NPI Number]

[Phone Number]