

**Date:** [Insert Date]

**TO:** [Insurance Company Name]

**ATTN:** [Appeals/Authorization Department]

**FAX:** [Insert Fax Number]

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

**PATIENT NAME:** [Patient First and Last Name]

**DATE OF BIRTH:** [MM/DD/YYYY]

**POLICY ID:** [Insert Policy Number]

**GROUP NUMBER:** [Insert Group Number]

To Whom It May Concern,

I am writing to formally request coverage for a specialized pediatric adaptive stroller/manual wheelchair for my patient, [Patient Name], who is under my care for the treatment of Spina Bifida (ICD-10 Code: [Insert Code, e.g., Q05.9]).

**Clinical Diagnosis and Presentation:**

[Patient Name] presents with Spina Bifida, which has resulted in [mention specific complications, e.g., lower extremity paralysis, neurogenic bladder, and significant gross motor delays]. Due to these physiological impairments, the patient is non-ambulatory and lacks the trunk stability and lower body strength required for safe independent mobility or the use of a standard commercial stroller.

**Medical Necessity:**

The requested equipment, [Insert Brand and Model of Stroller], is medically necessary for the following reasons:

- **Postural Support:** The patient requires specialized lateral supports and a contoured seating system to prevent spinal deformities (scoliosis/kyphosis) associated with their condition.
- **Safety and Positioning:** Unlike standard strollers, this device provides a 5-point harness and tilt-in-space functionality to manage orthostatic hypotension and facilitate proper pressure redistribution to prevent skin breakdown.
- **Functional Mobility:** This equipment is essential for transporting the patient to medical appointments and participating in Activities of Daily Living (ADLs) that are otherwise impossible due to the patient's lack of mobility.

**Equipment Specifications:**

The following features are required to meet the patient's clinical needs:

[List specific features, e.g., Adjustable footrests, pelvic positioning belt, reclining backrest, etc.]

**Summary:**

A standard commercial stroller does not provide the necessary orthopedic support or durability

required for a child with Spina Bifida. Without this specialized equipment, the patient is at high risk for secondary complications, including joint contractures and pressure ulcers.

I strongly recommend the immediate approval of this request. Please contact my office at [Insert Phone Number] if further clinical documentation is required.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Clinic/Hospital Name]