

Date: [Date]

RE: [Patient Full Name]

Date of Birth: [DOB]

Insurance ID: [ID Number]

Diagnosis: [Diagnosis Name/ICD-10 Code]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to formally request the authorization and coverage for a specialized pediatric mobility stroller ([Specific Model/Brand Name]). [Patient Name] is currently under my care for [Diagnosis], which significantly impacts their physical mobility and postural stability.

Clinical Assessment:

The patient presents with [list symptoms, e.g., hypotonia, spasticity, inability to ambulate independently, or poor trunk control]. Due to these physical limitations, a standard commercial stroller does not provide the necessary medical support or safety features required for the patient's daily functional needs.

Medical Necessity:

The requested specialized mobility stroller is medically necessary for the following reasons:

- **Postural Support:** Provides specialized seating and lateral supports to prevent skeletal deformities and maintain airway patency.
- **Safety:** Equipped with a 5-point harness and tilt-in-space features to manage [seizure activity/orthostatic hypotension/fatigue].
- **Growth/Durability:** Designed to accommodate the patient's growth and weight, which exceeds the limits of standard strollers.
- **Transportation:** Allows for safe transport to medical appointments and community integration while maintaining pelvic alignment.

Equipment Specifications:

The following features are required to meet the patient's clinical needs: [List specific features, e.g., Tilt-in-Space, Pelvic Belt, Head Support, Adjustable Footrests].

In summary, [Patient Name] requires this specialized equipment to maintain physiological integrity and ensure safe mobility. Please contact my office at [Phone Number] if further clinical documentation is required.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Clinic Name]

[NPI Number]