

Date: [Insert Date]
To: [Insurance Company Name]
Attention: Medical Review Department
Re: Letter of Medical Necessity for Specialized Pediatric Stroller

Patient Name: [Patient Name]
Date of Birth: [Patient DOB]
Policy/Member ID: [ID Number]
Group Number: [Group Number]
ICD-10 Codes: [Insert Diagnosis Codes, e.g., G80.9, J96.11]

Dear Medical Reviewer,

I am writing to formally request coverage for a specialized pediatric stroller with integrated respiratory equipment mounts for my patient, [Patient Name]. [Patient Name] has been diagnosed with [Primary Diagnosis] and [Secondary Diagnosis/Respiratory Condition].

Clinical Justification:

The patient currently presents with [describe physical limitations, e.g., inability to ambulate, poor trunk control, muscle spasticity]. Due to chronic respiratory failure and [describe specific need, e.g., ventilator dependency or supplemental oxygen requirements], the patient requires continuous access to life-sustaining medical equipment including:

- [Insert Equipment, e.g., Portable Ventilator]
- [Insert Equipment, e.g., Oxygen Cylinder/Concentrator]
- [Insert Equipment, e.g., Suction Machine]

Necessity of Specialized Equipment:

A standard consumer stroller or basic wheelchair is insufficient and unsafe for this patient. The requested specialized stroller is medically necessary for the following reasons:

- **Integrated Respiratory Mounts:** To ensure life-sustaining equipment is securely attached and remains functional during transport, preventing tubing disconnects or equipment falls.
- **Postural Support:** To provide necessary pelvic and trunk stability that the patient lacks, preventing skeletal deformities and skin breakdown.
- **Tilt-in-Space Functionality:** To allow for pressure relief and to optimize lung expansion and airway clearance.
- **Weight Capacity:** To safely accommodate both the patient's weight and the significant weight of the medical devices.

Conclusion:

Without this specialized equipment, [Patient Name] is unable to safely leave the home for medical appointments or community participation. This stroller is not for convenience, but is a vital component of the patient's daily medical management and safety. I strongly recommend the

approval of the [Insert Model Name/Manufacturer] stroller and all associated respiratory mounting hardware.

Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Clinic/Hospital Name]