

Date: [Insert Date]

To: [Insurance Company Name]

Attention: [Prior Authorization/Medical Review Department]

Address: [Insurance Address]

RE: Letter of Medical Necessity for Specialized Pediatric Stroller

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

Policy Number: [Policy Number]

Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request the authorization and coverage for a specialized pediatric adaptive stroller for my patient, [Patient Name]. [Patient Name] is currently under my care for [Diagnosis/Primary Medical Condition] which has resulted in **Severe Generalised Hypotonia (ICD-10: [Insert Code])**.

Clinical Assessment:

Due to severe low muscle tone, the patient lacks the trunk and head control necessary to maintain an upright, midline position. [Patient Name] is non-ambulatory and cannot safely utilize a standard commercial stroller or a standard wheelchair. Without specialized postural support, the patient is at high risk for spinal deformities, respiratory compromise, and skin breakdown.

Medical Necessity and Equipment Specifications:

A specialized pediatric stroller is medically necessary to provide the following essential supports:

- **Postural Support:** Specialized seating with lateral supports to prevent scoliosis and pelvic tilt.
- **Head Support:** An integrated headrest to maintain an open airway, as the patient cannot support their own head.
- **Tilt-in-Space Function:** To allow for pressure redistribution, improved respiratory function, and management of autonomic dysfunction.
- **Safety Harnessing:** A five-point positioning harness to prevent the patient from sliding out of the seat due to lack of muscle tension.

Functional Goals:

The goal of this equipment is to provide safe transportation for medical appointments, facilitate physiological stability, and prevent secondary orthopedic complications. This equipment is not for convenience; it is a primary piece of durable medical equipment required for the patient's daily safety and health maintenance.

I have determined that a standard stroller is clinically contraindicated for this patient. Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[NPI Number]

[Clinic/Hospital Name]