

DATE: [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: [DOB]

POLICY NUMBER: [Policy ID]

DIAGNOSIS: [ICD-10 Code and Description]

To Whom It May Concern,

This letter is written on behalf of [Patient Name] to request the authorization and purchase of a [Specific Brand/Model of Stroller]. [Patient Name] is currently under my care at [Clinic Name] for the treatment of [Primary Diagnosis].

Clinical Status:

The patient presents with [List symptoms, e.g., hypotonia, inability to ambulate, poor trunk control, seizures]. Due to these physical and functional limitations, a standard commercial stroller or wheelchair does not provide the necessary support or safety requirements for the patient's medical needs.

Medical Necessity:

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

- **Postural Support:** The patient requires [Specific features, e.g., lateral supports, contoured seating] to maintain an upright position and prevent skeletal deformities.
- **Safety:** A standard stroller lacks the [Five-point harness/Tilt-in-space] required to prevent the patient from falling or sliding during transport.
- **Medical Equipment Accommodation:** This stroller is designed to securely carry the patient's [Oxygen/Ventilator/Feeding Pump] which is essential for life safety during mobility.
- **Functional Mobility:** The equipment will allow the patient to be transported to medical appointments and therapy sessions safely.

Equipment Specifications:

The following components are required for the patient's specific needs:

[List specific accessories, e.g., Headrest, Padded Pelvic Belt, Sun Canopy, Oxygen Tank Holder].

Summary:

It is my professional opinion that the [Brand/Model] is the least costly equipment that meets the

patient's medical and functional requirements. Without this specialized stroller, the patient is at risk for [List risks, e.g., respiratory distress, skin breakdown, or injury].

Please contact me at [Phone Number] if further information is required.

Sincerely,

[Physician/Therapist Signature]

[Printed Name and Title]

[NPI Number]

[Clinic Name]