

Date: [Insert Date]

To: [Insurance Provider Name / Benefit Administrator]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

Policy/Member ID: [Insert ID Number]

Subject: Letter of Medical Necessity for Medical Gym Membership and Fitness Therapy

To Whom It May Concern,

I am writing to formally recommend a medically supervised gym membership and fitness therapy for my patient, [Patient Name].

Clinical Diagnosis:

The patient has been diagnosed with the following medical condition(s):
[Insert Diagnosis/ICD-10 Codes, e.g., Obesity E66.9, Hypertension I10, Type 2 Diabetes E11.9]

Medical Necessity:

Based on the patient's current health status, physical activity is a clinical necessity rather than a general wellness request. This treatment is required to:

- Manage and reduce symptoms associated with [Condition].
- Prevent further physical deterioration or secondary complications.
- Improve cardiovascular health and metabolic function.
- [Insert specific goal, e.g., Lower HbA1c levels or reduce BMI].

Treatment Plan:

I am prescribing a structured fitness program at a medical gym facility for a duration of [Number] months, with a frequency of [Number] sessions per week. This facility provides the necessary professional supervision and equipment required to safely manage the patient's specific limitations.

In my professional opinion, this intervention is an essential component of the patient's overall medical treatment plan and is necessary to improve their health outcomes.

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

Sincerely,

[Physician Signature]

Physician Name: [Insert Name]

NPI Number: [Insert NPI]

Practice Name: [Insert Clinic Name]