

[Physician Name/Clinic Name]

[Address]

[City, State, Zip Code]

[Phone Number]

[Date]

To: [Insurance Company Name / Transportation Provider]

Attn: Prior Authorization Department

Fax: [Fax Number]

RE: Letter of Medical Necessity for Non-Emergency Medical Transportation

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Member ID: [ID Number]

Treatment Frequency: [Number] times per week

To Whom It May Concern,

I am writing to formally request non-emergency medical transportation for the above-named patient. This patient is currently under my care for End-Stage Renal Disease (ESRD) and requires life-sustaining hemodialysis treatments.

The patient is medically unable to use public transportation or drive themselves due to the following conditions:

- [Condition 1: e.g., Severe post-dialysis fatigue/hypotension]
- [Condition 2: e.g., Limited mobility/use of wheelchair or walker]
- [Condition 3: e.g., Visual impairment or cognitive deficit]

Based on these medical limitations, the patient requires the following level of transport: [Ambulatory / Wheelchair Van / Stretcher].

Dialysis is a life-saving treatment. Failure to attend these scheduled appointments will result in acute medical crisis, hospitalization, or death. Regular transportation is medically necessary for the management of their condition.

This authorization is requested for the period of [Start Date] to [End Date/One Year].

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

Sincerely,

[Physician Signature]

[Physician Printed Name]

[NPI Number]