Date: [Insert Date]

TO: [Insurance Company Name / Administrative Body]
ATTN: [Department/Contact Person Name]
FAX/ADDRESS: [Insert Fax Number or Address]

RE: Letter of Medical Necessity for Wheelchair Van Transport
Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [ID Number]
Provider NPI: [Doctor NPI Number]

To Whom It May Concern,

I am writing to formally document the medical necessity of non-emergency medical transportation (NEMT) via a specialized wheelchair van for [Patient Name] to attend physical therapy sessions at [Clinic Name].

Clinical Diagnosis:
[Patient Name] is currently under my care for [List Diagnosis, e.g., Spinal Cord Injury, Multiple Sclerosis, Post-Operative Recovery]. Due to this condition, the patient presents with [List Functional Limitations, e.g., inability to ambulate, complete dependence on a power wheelchair, or inability to transfer to a standard vehicle].

Justification for Wheelchair Van:
Transportation via a standard passenger vehicle or public transit is contraindicated for this patient because:

- The patient requires a hydraulic lift or ramp to enter/exit a vehicle safely.
- The patient must remain in their wheelchair during transport to maintain postural stability and prevent injury.
- [Optional: The patient requires specialized tie-downs and safety restraints only found in wheelchair-accessible vehicles.]

Treatment Plan:
Physical therapy is medically necessary to [List Goals, e.g., prevent muscle atrophy, improve range of motion, or regain functional independence]. The patient is scheduled for [Number] sessions per week for a duration of [Number] months. Failure to attend these sessions due to lack of appropriate transport will result in significant physical decline and potential complications.

In summary, a wheelchair-accessible van is the only safe and medically appropriate method of transport for this patient to access essential rehabilitative care. Please approve this request for [Start Date] through [End Date].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical Practice Name]
[Phone Number]