

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert Patient DOB]

Member ID: [Insert Insurance ID Number]

To Whom It May Concern:

I am writing this letter to formally document the medical necessity for **[Patient Name]** to receive recurring Non-Emergency Medical Transportation (NEMT) services.

The patient is currently under my care for the following medical condition(s):

Diagnosis/ICD-10 Code: [Insert Diagnosis and Code]

Due to these conditions, the patient suffers from functional limitations that prevent them from using public transportation or driving themselves. These limitations include:

- [e.g., Cognitive impairment/Disorientation]
- [e.g., Physical disability requiring wheelchair access]
- [e.g., Severe visual impairment]
- [e.g., High risk of falls or injury]

The patient requires transportation for recurring appointments scheduled **[Frequency, e.g., three times per week]** for the purpose of **[Treatment type, e.g., Dialysis, Physical Therapy, Chemotherapy]**. Failure to attend these appointments will likely result in a significant decline in health or emergency hospitalization.

Required Mode of Transport:

Standard Sedan

Wheelchair Van

Stretcher Van

This medical necessity is expected to last for a duration of **[Insert Time Period, e.g., 6 months or Permanent]**.

Sincerely,

Physician Signature: _____

Physician Name: [Insert Printed Name]

NPI Number: [Insert NPI]

Phone Number: [Insert Clinic Phone]