Date: [Date]
To: [Insurance Provider Name / Transportation Coordinator]
Fax/Address: [Recipient Address or Fax Number]

RE: Letter of Medical Necessity for Ambulatory Transport Services
Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Provider/Clinic: [Name of Outpatient Clinic]

To Whom It May Concern,

I am writing to formally request and certify the medical necessity of ambulatory transport services for the above-mentioned patient. This request is for transport between the patient's residence and [Name of Clinic] for scheduled medical appointments.

Clinical Justification:
The patient is currently under my care for the following diagnosis/diagnoses: [List Primary Diagnosis, e.g., Severe Osteoarthritis, Visual Impairment, Cognitive Decline]. Due to these medical conditions, the patient is unable to utilize public transportation or drive themselves safely.

Functional Limitations:
The patient requires ambulatory transport assistance because:

- [Reason 1: e.g., Patient requires the use of a walker and physical assistance to enter/exit a vehicle.]
- [Reason 2: e.g., Patient suffers from severe vertigo/imbalance, posing a significant fall risk.]
- [Reason 3: e.g., Patient has cognitive impairments and cannot navigate transit systems independently.]

Duration of Need:
These services are required for the period of [Start Date] to [End Date] at a frequency of [Number] visits per [Week/Month].

Without reliable ambulatory transport, this patient is at high risk for non-compliance with their treatment plan, which may lead to clinical deterioration and avoidable emergency department visits.

Please contact our office at [Phone Number] if further documentation is required to approve this request.

Sincerely,

[Physician Signature]

[Physician Name, Credentials]
NPI Number: [NPI Number]
Clinic Name: [Clinic Name]