

[Date]
[Insurance Company Name / Transportation Provider]
[Address]
[City, State, Zip Code]

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

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Policy/ID Number: [ID Number]

To Whom It May Concern,

I am writing to formally request medical transportation coverage for [Patient Name], who is currently under my care for [Specific Diagnosis/Type of Cancer]. The patient is scheduled to undergo a course of chemotherapy treatment starting on [Start Date] with a frequency of [Number of sessions per week/month].

Medical transportation is a clinical necessity for this patient due to the following reasons:

- **Treatment Side Effects:** Chemotherapy often causes severe fatigue, dizziness, nausea, and cognitive impairment ("chemo brain"), making it unsafe for the patient to operate a motor vehicle.
- **Immunocompromised Status:** Due to suppressed immune function, the patient must avoid crowded public transportation to minimize the risk of infection.
- **Physical Limitations:** [Optional: Mention specific mobility issues, weakness, or lack of access to a private vehicle/caregiver].

Reliable transportation is vital to ensure treatment compliance and to prevent complications associated with missed appointments. We request that you approve [Type of transport: e.g., ambulatory van, wheelchair van, or taxi service] for all scheduled oncology visits.

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

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]
[Practice/Hospital Name]