Date: [Insert Date]

To: [Insurance Company Name / Transport Coordinator]
Fax/Email: [Insert Contact Information]
Re: Letter of Medical Necessity for Inter-Facility Transport

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Insurance ID: [ID Number]
Current Facility: [Sending Facility Name]
Receiving Facility: [Receiving Specialist Clinic/Hospital Name]

To Whom It May Concern,

I am writing to formally request and document the medical necessity for the inter-facility transport of the above-named patient from [Sending Facility] to [Receiving Facility].

Clinical Justification:
The patient is currently diagnosed with [Diagnosis/Condition]. Transfer is required because the current facility lacks the specialized resources necessary for the patient's continued care, specifically [Reason: e.g., Cardiac Catheterization, Advanced Surgical Intervention, Specialist Consultation].

Level of Service Required:
The patient requires transport via [Select One: BLS / ALS / SCT / Air Ambulance] due to the following medical requirements during transit:

- [Requirement 1: e.g., Continuous cardiac monitoring]
- [Requirement 2: e.g., Maintenance of IV infusions]
- [Requirement 3: e.g., Supplemental oxygen/Ventilator support]

Risk of Delay:
Failure to transfer this patient to a higher level of care may result in [State potential negative outcome/complication].

Please expedite the approval for this medically necessary transport.

Sincerely,

[Physician Name, MD/DO]
[Medical Specialty]
[NPI Number]
[Phone Number]