

**Date:** [Insert Date]

**To:** [Insurance Company Name/Transportation Provider]

**Attention:** [Department Name]

**Fax/Address:** [Insert Contact Information]

**RE: Letter of Medical Necessity for Oxygen-Supported Non-Emergency Transport**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [MM/DD/YYYY]

**Policy/Member ID:** [Insert ID Number]

To Whom It May Concern,

I am writing to formally document the medical necessity for oxygen-supported non-emergency medical transportation (NEMT) for the above-referenced patient. [Patient Name] is currently under my care for the treatment of [Primary Diagnosis/ICD-10 Code].

The patient requires continuous supplemental oxygen at a flow rate of [Insert Number] Liters Per Minute (LPM). Due to the patient's clinical condition, they are unable to utilize standard public or private transportation for the following reasons:

- The patient requires a constant, regulated supply of medical-grade oxygen during transit.
- The patient's mobility is severely limited by [Dyspnea/Respiratory Failure/Chronic Condition].
- The patient requires monitoring by trained personnel to ensure oxygen delivery systems remain functional and adequate during the duration of the trip.
- [Optional: Patient is bedbound and requires stretcher transport in addition to oxygen.]

**Transport Details:**

**From:** [Origin Address/Facility]

**To:** [Destination Address/Facility]

**Frequency:** [One-time / Recurring - e.g., 3 times per week]

In my professional medical opinion, specialized transport with oxygen support is essential to the patient's safety and to prevent acute respiratory distress. Conventional transportation would pose a significant risk to the patient's health.

Please contact my office at [Phone Number] if further clinical documentation is required for the authorization of these services.

Sincerely,

[Physician Signature]

**[Physician Name, MD/DO]**

**NPI Number:** [Insert NPI]

**Practice Name:** [Insert Practice Name]