[Date]

To: [Insurance Company Name / Transportation Coordinator]
Attention: [Department Name]
Fax/Phone: [Fax or Phone Number]

RE: Letter of Medical Necessity for Specialized Medical Transportation

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Member ID: [Insurance ID Number]
Provider: [Physician Name], [Pediatric Clinic Name]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to formally request authorization for specialized medical transportation for the purpose of attending necessary medical appointments and therapy sessions.

Diagnosis and Clinical Status:
The patient is currently being treated for [Diagnosis/ICD-10 Codes]. Due to the patient's medical condition, they present with the following limitations: [e.g., physical disability, requirement for supplemental oxygen, behavioral challenges, or use of a non-folding wheelchair].

Medical Necessity:
Standard public transportation or a private vehicle is not a viable option for this patient because: [List specific reasons, e.g., the patient requires a lift-equipped vehicle, professional monitoring during transport, or is unable to sit upright for extended periods].

Requested Mode of Transport:
Based on the patient's clinical needs, I am recommending: [Wheelchair Van / Stretcher Van / Basic Life Support Ambulance].

Frequency and Duration:
These transportation services are required for [Number] visits per [Week/Month] for a duration of [Number of months] to ensure the patient receives consistent care at [Name of Hospital/Specialty Center].

Failure to provide specialized transportation will result in missed appointments, which would significantly jeopardize the patient's health and treatment progress.

Please contact our office at [Clinic Phone Number] if you require additional information.

Sincerely,

[Physician Signature]
[Physician Name, Title]
[NPI Number]
[Pediatric Clinic Name]