[Physician Name/Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

To: [Insurance Company Name/Transportation Provider]
Attn: Prior Authorization Department
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Policy/Member ID: [ID Number]

Subject: Letter of Medical Necessity for Non-Emergency Medical Transportation (NEMT)

To Whom It May Concern,

I am writing to formally request Non-Emergency Medical Transportation (NEMT) coverage for [Patient Name] for travel to and from [Wound Care Clinic Name]. This patient is currently under my care for the treatment of [Specific Diagnosis, e.g., Chronic Stage IV Pressure Ulcers / Diabetic Foot Ulcers].

The patient requires specialized wound care treatments including [List treatments, e.g., debridement, compression therapy, or hyperbaric oxygen therapy] occurring [Frequency, e.g., three times per week]. These treatments are medically necessary to prevent infection, sepsis, and potential amputation.

NEMT is required due to the following physical limitations:

- [Reason 1: e.g., Patient is non-ambulatory and requires a wheelchair-accessible vehicle.]
- [Reason 2: e.g., Severe pain and limited mobility preventing the use of public transportation.]
- [Reason 3: e.g., Requirement for specialized positioning during transit to prevent pressure on existing wounds.]

Due to these clinical factors, the patient is unable to utilize standard private or public transportation safely. This transportation is essential for the patient to remain compliant with their life-sustaining treatment plan.

The anticipated duration of this transportation need is [Expected Duration, e.g., 6 months].

Please contact my office at [Phone Number] if further clinical documentation is required.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[NPI Number]