

[Date]

[Insurance Company/Payer Name]

[Address Line 1]

[City, State, Zip Code]

RE: Exhaustion of Alternative and Manual Mobility Devices

Patient Name: [Patient Full Name]

Policy Number: [Policy Number]

Claim Number: [Claim Number, if applicable]

Date of Birth: [DOB]

To Whom It May Concern,

I am writing to formally document the exhaustion of all alternative and manual mobility devices for the above-named patient. Based on a comprehensive clinical evaluation, it has been determined that standard manual wheelchairs and lesser mobility aids are insufficient to meet the patient's functional needs.

The following alternatives have been considered and ruled out for the reasons stated below:

- **Cane/Walker:** Ruled out due to [Reason, e.g., severe balance deficit or high fall risk].
- **Standard Manual Wheelchair:** Ruled out because the patient lacks the upper extremity strength/range of motion to self-propel.
- **Lightweight/Hemi-Wheelchair:** Ruled out because the patient cannot safely operate the device for required daily distances.
- **Power Operated Vehicle (Scooter):** Ruled out due to [Reason, e.g., inability to transfer safely or lack of postural support].

The patient's condition, [Diagnosis], results in functional limitations that prevent them from performing Activities of Daily Living (ADLs) using any of the manual devices listed above. Specifically, the patient is unable to [State specific functional failure, e.g., reach the kitchen or bathroom independently].

Therefore, a [Specific Device Being Requested, e.g., Power Wheelchair] is medically necessary as it is the least restrictive and only viable device that allows the patient to achieve functional mobility within the home.

Supporting clinical documentation, including the physical therapy evaluation and physician's notes, is attached for your review.

Sincerely,

[Signature]

[Printed Name and Credentials]

[Facility Name]
[Phone Number]