

Date: [Insert Date]

To: [Insurance Company Name/Review Board]

Attention: [Claims Department/Medical Director]

Address: [Insert Address]

Fax/Phone: [Insert Contact Information]

RE: Letter of Medical Necessity for Motorized Wheelchair

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

Policy/Member ID: [Member ID Number]

Diagnosis/ICD-10 Codes: [Insert Relevant Codes, e.g., G82.20, M32.9]

To Whom It May Concern,

I am writing to formally recommend the procurement of a motorized wheelchair for my patient, [Patient Name]. As their treating physician, I have determined that this equipment is medically necessary to provide mobility and prevent further physical complications.

Clinical Evaluation:

The patient suffers from [Name of Primary Condition], which results in [List Symptoms: e.g., severe muscle weakness, paralysis, respiratory distress, or extreme fatigue]. Due to these clinical findings, the patient is unable to self-propel a manual wheelchair and lacks the upper extremity strength or endurance to perform Activities of Daily Living (ADLs) safely within their home.

Justification for Power Mobility:

A manual wheelchair is not a viable option because [Reason: e.g., risk of repetitive strain injury, cardiac limitations, or insufficient strength]. A motorized wheelchair is required to allow the patient to:

- Perform independent mobility for grooming and feeding.
- Navigate their living environment without the assistance of a caregiver.
- Reduce the risk of pressure ulcers through [Specific Feature: e.g., power tilt/recline functions].

Equipment Recommendation:

I am prescribing a [Specific Model/Type of Power Wheelchair] with the following necessary modifications: [List Accessories: e.g., specialized seating, joystick controls, headrests].

Duration of Need:

The patient's condition is [Chronic/Permanent], and the equipment is expected to be required for [Number of Years/Lifetime].

I request that you approve the coverage for this essential medical equipment. If you require further clinical documentation or physical therapy evaluations, please contact my office.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

NPI Number: [NPI Number]

Clinic/Hospital Name: [Facility Name]

Phone: [Phone Number]