[Your Name]
[Your Address]
[Your Phone Number]
[Your Email]

[Date]

[Recipient Name or Medical Equipment Provider]
[Organization Name]
[Address]

RE: Prescription and Letter of Medical Necessity for Motorized Wheelchair

To Whom It May Concern,

I am writing to formally request a specialized motorized wheelchair for [Patient Name], born on [Date of Birth], due to the following medical diagnosis: [Insert Diagnosis].

Standard mobility devices do not meet the patient's clinical needs. The following specific requirements and modifications are medically necessary for safety, postural support, and independence:

- **Drive Control System:** [e.g., Alternative joystick, head control, or chin control] to accommodate [specific physical limitation].
- **Power Seating Functions:** [e.g., Power tilt-in-space, recline, or elevating leg rests] required for pressure relief and management of [condition].
- **Seating and Positioning:** [e.g., Custom contoured backrest, lateral trunk supports, or specialized headrest] to prevent skeletal deformity.
- **Dimensions and Weight Capacity:** [e.g., Reinforced frame or specific seat width/depth] to accommodate the patient's size and weight.
- **Modifications for Environmental Access:** [e.g., Specific tire types or curb-climbing capabilities] for essential daily navigation.

These modifications are essential for the patient to perform Activities of Daily Living (ADLs) and to prevent further medical complications such as pressure sores or respiratory distress.

Please find the attached clinical evaluation and detailed specifications from the physical therapist. If you require further documentation, please contact me at [Phone Number].

Sincerely,

[Your Signature / Physician Signature]
[Printed Name and Credentials]
[NPI Number]