

[Date]

[Insurance Company Name]  
[Attn: Medical Review/Appeals Department]  
[Address]  
[City, State, Zip Code]

**RE: Letter of Medical Necessity for Continuation of Post-Operative Rehabilitation**

**Patient Name:** [Patient Name]  
**Date of Birth:** [DOB]  
**Member ID:** [ID Number]  
**Group Number:** [Group Number]  
**Claim/Reference Number:** [Reference Number]

To Whom It May Concern,

I am writing to formally request the authorization for continued post-operative rehabilitation services for [Patient Name]. This request is following a [Type of Surgery] performed on [Date of Surgery].

**Clinical Progress:**

Since beginning rehabilitation, the patient has demonstrated progress in [mention specific improvements, e.g., range of motion, weight-bearing status, or pain management]. However, the patient has not yet reached their baseline functional status or the goals outlined in the initial surgical recovery plan.

**Current Functional Deficits:**

At this time, the patient continues to experience [list specific deficits, e.g., muscle weakness, gait instability, or inability to perform activities of daily living]. Current objective measurements include: [Insert specific degrees of motion, strength grades, or balance scores].

**Necessity for Continued Care:**

Continued skilled [Physical/Occupational] therapy is medically necessary to [list goals, e.g., prevent joint contracture, ensure safe ambulation, or avoid post-operative complications]. Discontinuing treatment at this stage would significantly increase the risk of [mention risks, e.g., permanent loss of function, surgical failure, or falls].

**Proposed Plan:**

I am recommending an additional [Number] of sessions over the next [Number] weeks. The focus of these sessions will be [specific focus, e.g., neuromuscular re-education, strengthening, and functional mobility training].

Thank you for your prompt attention to this request. Please contact my office at [Phone Number] if further clinical documentation is required.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]