[Physician Name/Clinic Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]
[Date]

[Insurance Company Name]
[Attention: Medical Review Department]
[Address Line 1]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Continuation of Neurological Rehabilitation
Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Policy/Member ID: [ID Number]
Claim/Reference Number: [Reference Number, if applicable]

To Whom It May Concern,

I am writing to formally request the authorization for continued neurological rehabilitation services for [Patient Name]. The patient has been under my care since [Date] following a diagnosis of [Diagnosis/Condition, e.g., Traumatic Brain Injury, Stroke, Multiple Sclerosis].

Clinical Progress and Current Status:
Since beginning treatment on [Start Date], the patient has demonstrated progress in [List specific functional improvements, e.g., gait stability, cognitive processing, or fine motor skills]. However, the patient continues to present with significant deficits, including [List remaining impairments].

Treatment Plan and Goals:
The requested continuation of care (including [Physical/Occupational/Speech] therapy) is medically necessary to achieve the following objective goals:

- [Goal 1: e.g., Increase walking distance to 200ft without assistance]
- [Goal 2: e.g., Improve executive functioning for independent living]
- [Goal 3: e.g., Reduce risk of secondary complications or falls]

Medical Necessity:
Discontinuation of services at this stage would likely result in a regression of functional gains, loss of independence, and an increased risk of [Medical complications/re-hospitalization]. Continued intensive rehabilitation is required to reach the patient's maximum functional potential.

I am requesting authorization for [Number] additional sessions over the next [Number] weeks/months. Please contact my office at [Phone Number] if further clinical documentation is required.

Sincerely,

[Physician Signature]
[Physician Name, Credentials]
[NPI Number]