[Date]
[Insurance Company Name]
[Claims/Appeals Department Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Continued Rehabilitative Services

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Policy Number: [Policy Number]
Group Number: [Group Number]
Claim Number: [Claim Number (if applicable)]

To Whom It May Concern,

I am writing to formally request the authorization for continued [Physical/Occupational/Speech] therapy services for [Patient Name]. The patient has been under my care since [Start Date] for the treatment of [Primary Diagnosis/ICD-10 Code] following [Date of Injury/Surgery].

Current Clinical Status:
[Patient Name] has made steady progress toward their functional goals; however, they have not yet reached their maximum medical improvement. Currently, the patient presents with [List current deficits, e.g., limited range of motion, muscle weakness, or speech impediments].

Necessity of Continued Treatment:
Ongoing rehabilitative therapy is medically necessary to [List specific goals, e.g., restore independent ambulation, prevent permanent joint contracture, or ensure safe swallowing]. Without continued skilled intervention, the patient is at high risk for [List risks, e.g., functional decline, surgical revision, or loss of independence].

Proposed Treatment Plan:
I am recommending an additional [Number] weeks of therapy at a frequency of [Number] sessions per week. This plan focuses on [Specific techniques or interventions].

Included with this letter are the most recent clinical evaluations and progress notes supporting this request. Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

[Physician/Therapist Signature]
[Printed Name and Credentials]
[National Provider Identifier (NPI)]
[Facility Name]