Date: [Date]

To: [Insurance Company Name / Utilization Review Department]
Attn: [Case Manager Name, if known]
Fax/Email: [Fax Number or Email Address]

RE: Clinical Justification for Inpatient Rehabilitation Facility (IRF) Admission

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Requesting Provider: [Physician Name]
Facility Name: [Name of Rehab Facility]

Dear Medical Review Team,

I am writing to provide clinical justification for the admission of the above-mentioned patient to an Inpatient Rehabilitation Facility (IRF). The patient was recently hospitalized on [Admission Date] for [Primary Diagnosis/Surgery/Injury].

Clinical Status:
The patient currently presents with the following functional deficits:

- [Functional Deficit 1, e.g., inability to ambulate safely]
- [Functional Deficit 2, e.g., dependence for ADLs]
- [Functional Deficit 3, e.g., cognitive or speech impairment]

Justification for Intensive Rehabilitation:
The patient requires the intensive level of care provided by an IRF based on the following criteria:

- **Multidisciplinary Care:** The patient requires at least two therapeutic modalities (PT, OT, and/or SLP).
- **Intensity of Therapy:** The patient is medically stable and able to participate in a minimum of 3 hours of therapy per day, 5 days per week.
- **Medical Supervision:** The patient requires 24-hour nursing care and face-to-face physician oversight (at least 3 days per week) due to [Co-morbidities or Medical Risks].
- **Potential for Improvement:** There is a high expectation for measurable functional improvement within a reasonable timeframe.

Alternative Settings:
Lower levels of care, such as Skilled Nursing (SNF) or Home Health, are inappropriate at this time because [Reason, e.g., patient lacks the safety/stamina for home; SNF does not provide the required frequency of physician oversight or therapy intensity].

The goal of this admission is to return the patient to their prior level of function and facilitate a safe discharge to [Discharge Destination]. Please contact my office at [Phone Number] if further documentation is required.

Sincerely,

[Physician Signature]
[Physician Name and Title]
[NPI Number]