Date: [Date]

To: [Paratransit Provider Name]
Department: Eligibility Department
Address: [Provider Address]

Subject: Medical Certification for Paratransit Services

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Patient ID/Account Number: [ID Number, if applicable]

To Whom It May Concern,

I am writing to certify the medical necessity of paratransit services for the above-named patient. The patient is currently under my care for End-Stage Renal Disease (ESRD) and requires life-sustaining dialysis treatments.

Treatment Schedule:
The patient is scheduled for dialysis [Number] times per week on [Days of the Week, e.g., Mon/Wed/Fri] at [Facility Name].

Medical Justification:
Due to the patient's medical condition and the physical exhaustion associated with dialysis treatment, they are unable to independently navigate or utilize standard fixed-route public transportation. Specific limitations include:

- Severe fatigue and weakness following treatment.
- [Optional: Mobility limitations/use of assistive devices].
- [Optional: Risk of hypotension or dizziness post-dialysis].

In my professional medical opinion, this patient requires door-to-door or curb-to-curb paratransit assistance to ensure safe and reliable access to their medical appointments. This condition is expected to be [Permanent / Long-term for X months].

If you require further clinical information, please contact my office at [Phone Number].

Sincerely,

[Doctor Signature]
[Doctor Name, MD/DO]
[Medical License Number]
[Clinic/Facility Name]
[Contact Information]