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

[Insurance Company Name]
[Prior Authorization Department]
[Address]
[City, State, Zip Code]

**RE: Letter of Medical Necessity for [Patient Name]**

**DOB:** [Patient Date of Birth]
**ID Number:** [Policy ID Number]
**Diagnosis:** [ICD-10 Code and Description]

To Whom It May Concern,

I am writing to formally request a custom manual wheelchair for my patient, [Patient Name]. This equipment is medically necessary to provide functional mobility and prevent secondary complications related to [Diagnosis].

**Clinical Assessment:**
The patient presents with [list physical limitations, e.g., muscle weakness, paralysis, inability to ambulate]. Due to these limitations, the patient is unable to complete Activities of Daily Living (ADLs) within the home using a standard wheelchair or walker.

**Equipment Requirements:**
A standard wheelchair is insufficient for this patient because [list reasons, e.g., weight of chair, lack of postural support]. The following custom features are required:

- [Feature 1, e.g., Ultra-lightweight frame]: Necessary for [reason].
- [Feature 2, e.g., Custom pressure-relieving cushion]: Necessary to prevent skin breakdown.
- [Feature 3, e.g., Adjustable axle plate]: Necessary for ergonomic propulsion.

**Medical Justification:**
Without this custom manual wheelchair, the patient is at high risk for [list risks, e.g., pressure sores, shoulder injury, complete loss of independence]. This specific configuration is the least costly alternative that meets the patient's medical and functional needs.

I have performed a physical evaluation and determined that the patient has the upper extremity strength and cognitive ability to safely operate this custom manual wheelchair.

Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[NPI Number]