Date: [Insert Date]

To: [Insurance Company Name]
Attention: [Prior Authorization/Medical Review Department]
Fax/Address: [Insert Fax Number or Address]

RE: Letter of Medical Necessity for Power Mobility Scooter

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Policy/Member ID: [Insert ID Number]
Group Number: [Insert Group Number]

To Whom It May Concern,

I am writing to formally document the medical necessity of a Power Mobility Scooter (HCPCS Code: [Insert Code, e.g., K0801]) for my patient, [Patient Name].

Diagnosis:
The patient suffers from [List Primary Diagnosis, e.g., Severe Osteoarthritis, COPD, Multiple Sclerosis] (ICD-10 Code: [Insert Code]). This condition results in significant mobility limitations that prevent the patient from performing Activities of Daily Living (ADLs) within the home.

Clinical Justification:
Based on my clinical evaluation, the patient meets the following criteria:

- The patient has a mobility limitation that significantly impairs their ability to participate in one or more MRADLs (Mobility-Related Activities of Daily Living) such as toileting, feeding, dressing, or grooming in the home.
- The patient's mobility limitation cannot be sufficiently resolved by the use of a cane or walker.
- The patient does not have sufficient upper extremity function to self-propel a manual wheelchair.
- The patient has the physical and cognitive ability to safely operate a power scooter.
- The patient's home environment has been evaluated and can accommodate the use of a power mobility device.

Treatment Plan:
The use of a power scooter is expected to improve the patient's mobility, reduce the risk of falls, and allow for independence within the home environment. This device is not being prescribed for use primarily outside of the home, but for essential daily functioning.

I am prescribing the following equipment: [Brand/Model of Scooter if applicable].

Please contact my office at [Phone Number] if further documentation or clarification is required for the approval of this essential medical equipment.

Sincerely,

[Physician Signature]
[Physician Printed Name]
NPI Number: [Insert NPI]
Practice Name: [Insert Practice Name]