Date: [Date]

To: [Insurance Company Name]
Attention: Medical Review Department
Address: [Insurance Company Address]

RE: Letter of Medical Necessity for a Pediatric Gait Trainer

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Member ID: [Insurance ID Number]
Diagnosis: [Primary Diagnosis/ICD-10 Code]

Dear Medical Reviewer,

I am writing to formally request the authorization for a pediatric gait trainer for [Patient Name]. This patient is currently under my care for [Diagnosis], which has resulted in significant motor delays and the inability to ambulate independently or safely without specialized equipment.

Clinical Status:
[Patient Name] presents with [Specific physical limitations, e.g., hypertonia, poor trunk control, ataxia]. Current assessment shows that the patient is unable to support their own body weight or maintain balance for functional walking. [He/She] requires maximum assistance for all mobility tasks.

Medical Necessity:
A pediatric gait trainer is medically necessary for this patient to:

- Provide the necessary postural support and alignment to facilitate weight-bearing.
- Improve bone density and prevent joint contractures through upright activity.
- Enhance cardiovascular and bowel/bladder function via weight-bearing mobility.
- Develop motor patterns required for future independent or assisted walking.
- Prevent further secondary complications associated with prolonged sitting and immobility.

Equipment Recommendation:
I am prescribing the [Specific Make and Model of Gait Trainer] with the following necessary accessories: [List accessories, e.g., pelvic support, arm prompts, headrest]. Less restrictive devices, such as standard walkers, have been ruled out because they do not provide the trunk and pelvic stability required for this patient to remain upright safely.

Expected Outcome:
With the use of this gait trainer, it is expected that [Patient Name] will gain increased lower extremity strength and improved functional mobility within the home and community environment.

Thank you for your prompt consideration of this request. Please contact me at [Phone Number] if you require further documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Clinic Name]