**Date:** [Date]

**TO:** [Insurance Company Name]
**ATTN:** [Prior Authorization/Appeals Department]
**FAX:** [Fax Number]

**RE:** [Patient Name]
**DOB:** [Date of Birth]
**ID #:** [Insurance ID Number]
**GROUP #:** [Group Number]

**Subject: Letter of Medical Necessity for Multi-Position Standing Frame**

To Whom It May Concern,

I am writing to formally request coverage for a multi-position standing frame (HCPCS Code: [Insert Code, e.g., E0638]) for my patient, [Patient Name]. [Patient Name] has been diagnosed with [Primary Diagnosis, e.g., Cerebral Palsy, Spinal Cord Injury, Muscular Dystrophy], which has resulted in [mention functional limitations, e.g., inability to stand independently or maintain upright posture].

**Clinical Justification:**
The patient currently presents with [List symptoms: e.g., hypertonicity, risk of contractures, low bone density]. Without the use of a multi-position standing frame, the patient is at significant risk for secondary medical complications, including pressure sores, skeletal deformities, and decreased bone mineral density.

**Medical Benefits of the Multi-Position Standing Frame:**
The requested equipment is medically necessary for this patient to:

- Improve and maintain bone density through weight-bearing.
- Prevent or reduce joint contractures and muscle atrophy.
- Enhance bowel and bladder function and improve circulation.
- Provide pressure relief by changing positions from sitting to standing.
- Facilitate proper hip joint development and alignment.

**Specific Requirements:**
A multi-position frame (Supine/Prone/Upright) is required because [Patient Name] requires [mention specific need, e.g., gradual acclimation to upright positioning or specific posterior support due to poor head control].

**Conclusion:**
This device is not for convenience or recreation but is a vital component of the patient's medical treatment plan. Failure to provide this equipment will likely lead to a decline in physical status and increased medical costs due to complications. Please approve this request for the [Manufacturer Name and Model] standing frame.

Sincerely,

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