Date: [Insert Date]

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

RE: Letter of Medical Necessity for Adaptive Ergonomic Seating System

Patient Name: [Insert Patient Name]
Date of Birth: [Insert DOB]
Member ID: [Insert ID Number]
Diagnosis Code(s): [Insert ICD-10 Codes]

To Whom It May Concern,

I am writing to formally recommend the purchase of an Adaptive Ergonomic Seating System for my patient, [Patient Name]. As their treating [Insert Specialty, e.g., Physical Therapist/Physician], I have determined that this specialized equipment is medically necessary due to the patient's clinical diagnosis of [Insert Diagnosis].

Clinical Status and Functional Limitations:
The patient currently presents with [describe specific symptoms, e.g., spinal instability, severe postural kyphosis, or pressure injury risks]. Standard seating is insufficient because it fails to provide the necessary [mention specific requirements, e.g., pelvic stabilization, lateral trunk support, or pressure redistribution].

Required Equipment Features:
The requested Adaptive Ergonomic Seating System must include the following medical features:

- [Feature 1: e.g., Adjustable Lumbar Support for spinal alignment]
- [Feature 2: e.g., Tilt-in-space or Recline for pressure relief]
- [Feature 3: e.g., Specialized Contoured Cushion for skin integrity]

Medical Necessity and Goals:
The primary goals for this seating system are to:

- Prevent further musculoskeletal deformities and secondary complications.
- Reduce chronic pain associated with [Condition].
- Allow the patient to maintain a functional upright position for activities of daily living.
- Prevent the development of Stage III/IV pressure ulcers.

Without this adaptive seating, the patient is at a significantly increased risk for [list risks, e.g., respiratory compromise, skin breakdown, or permanent loss of mobility]. This equipment is not for convenience or comfort but is a vital component of the patient's medical treatment plan.

Please contact me at [Phone Number] if you require additional clinical documentation.

Sincerely,

[Physician/Therapist Signature]
[Print Name and Credentials]
[NPI Number]
[Facility Name]