[Date]
[Insurance Company Name]
[Claims/Appeals Department]
[Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Continued Physical Therapy
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Claim/Reference Number: [Reference Number if applicable]

To Whom It May Concern,

I am writing to formally request an extension of physical therapy services for [Patient Name]. The patient is currently being treated for [Diagnosis/Condition] (ICD-10 Code: [Code]).

Clinical Progress to Date:
Since beginning treatment on [Start Date], the patient has completed [Number] sessions. The patient has shown the following improvements: [List specific improvements, e.g., increased range of motion by 20 degrees, improved gait stability].

Necessity for Continued Treatment:
Despite this progress, the patient has not yet reached their maximum functional potential. Currently, the patient continues to experience [List remaining deficits, e.g., persistent pain at 6/10, inability to climb stairs, weakness in lower extremities].

Proposed Plan of Care:
I am requesting an additional [Number] sessions over the next [Number] weeks. The goals for these sessions include:

- [Goal 1, e.g., Achieve full independent ambulation]
- [Goal 2, e.g., Increase strength to 5/5 in affected muscle groups]
- [Goal 3, e.g., Return to work/activities of daily living without assistance]

Without continued skilled intervention, the patient is at high risk for [List risks, e.g., regression, chronic disability, or surgical intervention].

Please contact my office at [Phone Number] if you require further clinical documentation or have any questions.

Sincerely,

[Provider Signature]
[Provider Name, Title]

[Facility Name]
[NPI Number]