Date: [Insert Date]

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

RE: Letter of Medical Necessity for Motorized Wheelchair

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Policy Number: [Insert Number]
Group Number: [Insert Number]

To Whom It May Concern,

I am writing to formally request authorization for a motorized wheelchair (Power Mobility Device) for my patient, [Patient Name]. [He/She] has been under my care for [Duration of Time] for the treatment of [Primary Diagnosis/ICD-10 Code].

Clinical Justification:
The patient suffers from [List specific physical limitations, e.g., severe muscle weakness, paralysis, or cardiac respiratory distress]. Due to these conditions, the patient is unable to perform Activities of Daily Living (ADLs) within the home using a cane, walker, or manual wheelchair. Specifically, the patient lacks the upper body strength and endurance required to propel a manual wheelchair safely.

Evaluation Results:
A physical evaluation conducted on [Date] confirmed that a motorized wheelchair is medically necessary to allow the patient to move independently and safely within their residence. Without this equipment, the patient is at a significant risk for [List risks, e.g., falls, pressure sores, or complete immobility].

Equipment Recommendation:
I am prescribing the following equipment: [Specific Model and Necessary Accessories/Modifications]. These features are required to accommodate the patient's [Specific need, e.g., orthopedic positioning or skin integrity requirements].

Statement of Medical Necessity:
In my professional medical opinion, this motorized wheelchair is not for convenience but is a vital component of the patient's treatment plan to prevent further functional decline and medical complications.

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

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
NPI Number: [Insert NPI]
Practice Name: [Insert Practice Name]