[Date]

[Payer Name]
[Appeals/Authorization Department]
[Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Inpatient Rehabilitation Facility (IRF) Admission

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Policy Number: [Policy ID]
Claim/Reference Number: [Reference Number]

To Whom It May Concern,

I am writing to formally request authorization for the admission of [Patient Name] to an Inpatient Rehabilitation Facility (IRF). Based on my clinical evaluation, the patient requires an intensive, interdisciplinary rehabilitation program that cannot be safely or effectively provided in a lower level of care.

Clinical Diagnosis and Background:
The patient was admitted on [Date] following [Primary Diagnosis/Surgical Procedure]. The patient's hospital course was complicated by [List Comorbidities or Complications].

Functional Deficits:
Currently, the patient demonstrates significant functional limitations in:
- [e.g., Mobility/Ambulation]
- [e.g., Activities of Daily Living/Self-Care]
- [e.g., Cognitive Processing/Speech]

Medical Necessity for IRF Level of Care:
The patient meets the following criteria for IRF placement:
1. **Intensity of Therapy:** The patient is able to participate in and requires at least 3 hours of therapy per day, at least 5 days per week, consisting of multiple modalities (PT, OT, and/or Speech).
2. **Medical Supervision:** The patient requires 24-hour rehabilitation nursing and frequent face-to-face physician visits (at least 3 days per week) to manage [Specific Medical Condition/Medications].
3. **Interdisciplinary Approach:** The patient requires a coordinated team approach to manage complex recovery goals and discharge planning.

Expected Outcome:
With the intensive services provided at an IRF, it is expected that the patient will achieve significant practical improvement in functional status, with the ultimate goal of returning to a [Home/Community] setting.

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

Sincerely,

[Physician Name, MD/DO]
[Title/Department]
[Facility Name]