

Date: [Insert Date]

To: [Insurance Company Name]

Attention: Utilization Review/Appeals Department

Fax/Address: [Insert Fax Number or Address]

RE: Request for Physical Therapy Visit Limit Exception

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

Member ID: [Insurance ID Number]

Group Number: [Group Number]

Claim/Reference Number: [If applicable]

To Whom It May Concern,

I am writing to formally request an authorization for additional physical therapy sessions for the above-mentioned patient. The patient has reached their initial benefit limit of [Number] sessions; however, further treatment is medically necessary to achieve functional goals and avoid clinical regression.

Clinical Justification:

- **Diagnosis:** [Insert Diagnosis and ICD-10 Code]
- **Date of Surgery/Injury:** [Insert Date]
- **Progress to Date:** [Briefly describe improvements in mobility or strength]
- **Reason for Extension:** [Describe remaining deficits, e.g., persistent pain, limited range of motion, or inability to perform daily tasks]

Requested Extension:

I am requesting an additional [Number] sessions over the next [Number] weeks. Without continued therapy, the patient is at high risk for [e.g., permanent loss of function, surgical failure, or chronic pain].

Attached you will find the current Plan of Care, progress notes, and the initial evaluation for your review.

Thank you for your prompt attention to this matter. Should you require further information, please contact my office at [Phone Number].

Sincerely,

[Provider Name/Signature]

[Provider Title/Credentials]

[Facility Name]
[NPI Number]