[Your Practice Name]
[Your Address]
[City, State, ZIP Code]
[Phone Number]
[Email Address]
[Date]

To Whom It May Concern:

Re: Letter of Medical Necessity for [Patient's Full Name]
DOB: [Patient's Date of Birth]
Diagnosis: [Primary Diagnosis]
Insurance Policy Number: [If applicable]

Dear Sir/Madam,

I am writing this letter on behalf of my patient, **[Patient's Full Name]**, to provide medical justification for the prescription of a **[Type of Wheelchair: e.g., Manual Ultra-lightweight Rigid Frame Wheelchair (K0005)]**.

Patient Overview:

[Patient's Full Name] is a **[Age]**-year-old individual with a diagnosis of **[Primary Diagnosis, e.g., spinal cord injury, cerebral palsy, multiple sclerosis]**, which significantly impacts their mobility and ability to perform activities of daily living (ADLs). The patient presents with **[list relevant impairments, e.g., motor sensory deficits, muscle weakness, decreased endurance, etc.]**.

Functional Status:

Due to the nature of their condition, **[Patient's First Name]** requires assistance with **[list impacted activities: e.g., transfers, mobility, or other ADLs]**. Currently, **[he/she/they]** is unable to ambulate safely using assistive devices such as **[ruling out alternatives like canes, walkers, or lower-level wheelchairs]**. This makes independent mobility with the recommended wheelchair medically necessary.

Justification for Wheelchair:

A wheelchair is essential for **[Patient's First Name]** to maintain independence in their home and community. **[He/She/They]** will use this wheelchair to perform the following essential tasks:

- **Mobility-Related ADLs (MRADLs):** Including but not limited to transferring, attending medical appointments, and moving between rooms in their home.

- **Recreational and Community Activities: [He/She/They]** will be able to participate in family life, work/school activities, and other community engagements.
- **Medical Concerns:** Without this equipment, **[Patient's First Name]** risks developing secondary medical issues, including **[e.g., pressure sores, muscle atrophy, contractures, etc.]**.

Specific Wheelchair Recommendations:

I am prescribing a **[Wheelchair Type: e.g., K0005 Manual Ultralight Wheelchair]** due to its ability to meet **[Patient's First Name]**'s unique needs. The key components that justify this specific wheelchair are as follows:

1. **Seating and Positioning Needs:** A **[seat/back type: e.g., pressure-relieving cushion, custom backrest]** is required to address **[specific issues like skin integrity, postural control]**.
2. **Mobility Requirements:** The **[Wheelchair Type]** allows **[Patient's First Name]** to self-propel independently, mitigating the risk of shoulder injuries due to the **[benefits such as lightweight frame or adjustable axle]**.
3. **Additional Features: [e.g., tilt, recline, leg rests, arm rests, head support]** are medically necessary for **[Patient's First Name]** to maintain proper posture, prevent contractures, and ensure comfort for long-term use.

Measurements:

- Shoulder Width: [Measurement]
- Chest Width: [Measurement]
- Hip Width: [Measurement]
- Leg Length: [Measurement]
- **[Add other relevant measurements]**

Conclusion:

Given **[Patient's First Name]**'s medical condition, the recommended wheelchair is crucial for improving functional independence and overall quality of life. I respectfully request that this equipment be approved for coverage under **[Patient's Insurance]**.

Please do not hesitate to contact me at **[Your Phone Number]** or via email at **[Your Email Address]** if further information is needed.

Sincerely,
[Your Full Name, PT/OT]
[Your Professional Title]
[Your License Number]