|  |  |
| --- | --- |
| [Enter Organization’s Name] | [Enter Organization’s Address][Enter Organization’s Phone Number][Enter Organization’s Fax Number] |

Letter of Medical Necessity

|  |  |  |  |
| --- | --- | --- | --- |
| **Date:** | 7/26/2019 | **Therapist:** |  |
| **Patient Name:** |  | **Referring MD:**  |  |
| **Date of Birth:** | Click to enter a date... | **Diagnosis Code:** |  |

**Name & Description of Item(s) Requested:**

|  |  |
| --- | --- |
| **Quantity** | **Description** |
| Please Choose | Choose a description... |
| Please Choose | Choose a description... |
| Please Choose | Choose a description... |

|  |
| --- |
| **History:** |

**[Patient Name] presents with the following deficits and functional limitations:**

|  |
| --- |
| Choose an item. |
| Choose an item. |
| Choose an item. |
| Choose an item. |
| Choose an item. |
| Choose an item. |

**The indicated item(s) is/are medically necessary as it will enable or enhance the patient’s ability to:**

|  |
| --- |
| Choose an item. |
| Choose an item. |
| Choose an item. |
| Choose an item. |
| Choose an item. |
| Choose an item. |

|  |
| --- |
| **Comments:**  |

Thank you for your prompt consideration of this matter. Please contact me at [Enter Organization’s Phone Number] with any questions.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** |  | **Date:** | 7/26/2019 |