Letter of Medical Necessity

PRESCRIPTION I LETTER OF MEDICAL NECESSITY

PHYSICIAN NAME: ______________________________________ PHONE: ________________________

ADDRESS: ____ FAX: __________________________

CITY/STATE/ZIP: ____

PATIENT'S NAME: ______________________________________ DOB: __________________________

DIAGNOSIS: ____

The above named patient has been under my care. I recommend the following mode of therapy or medical equipment.

THERAPY EVAL/TREAT FREQ PER WK DURATION ____________ (MONTHS)

OT (Occupational Therapy) PT {Physical Therapy) ST (Speech Therapy}

LIMITATIONS: ____

These modes of therapy are medically necessary to improve:

Muscle tone and strength Balance/coordination Mobility Fine/gross motor control Tongue/oral movements

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and to prevent the development of deformities or contractures, which may require surgical intervention. Description of Medical Equipment I Reason Needed:

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☐ I am planning to see this child back at regular intervals to re-evaluate the need for therapy or medical equipment.