[Your Name]
[Your Address]
[City, State, ZIP Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Insurance Company Address]
[City, State, ZIP Code]
Subject: Letter of Medical Necessity for Physical Therapy
Dear [Insurance Adjuster's Name],
I am writing to request prior authorization for physical therapy services for my patient, [Patient's Name], whose date of birth is [Patient's DOB]. [Patient's Name] has been under my care for [duration of treatment] and has been diagnosed with [specific diagnosis].
Based on my evaluation and ongoing assessment, it is my professional opinion that the recommended physical therapy is medically necessary for the following reasons:
1. **Diagnosis and Symptoms**: [Briefly describe the patient's condition and symptoms impacting their daily life.]

2. **Treatment Goals**: [Explain the specific goals of the proposed physical therapy.]
3. **Proven Benefits**: [Cite evidence or guidelines that support the use of physical therapy for this diagnosis.]
4. **Previous Treatments**: [Detail any prior treatments or therapies undertaken, and explain why they have not been sufficient.]
I recommend a course of physical therapy consisting of [frequency and duration of therapy sessions] to address [specific goals]. This treatment plan will help improve [mention specific functional outcomes] and enhance [patient's quality of life].
Please find attached relevant documentation, including [list supporting documents such as medical records, previous evaluations, and treatment plans].
I ask that you give this request for prior authorization your immediate attention. If you have any questions or require further information, please do not hesitate to contact me at [Your Phone Number] or [Your Email Address].
Thank you for your prompt attention to this matter.
Sincerely,
[Your Name]
[Your Title/Position]
[Your Practice Name]
[Your NPI Number]
[Your Contact Information]