



Letter of Medical Necessity (LMN) Sample Template

(Date)

TO WHOM IT MAY CONCERN:

“Client” “Last Name” is a **“age”** year old **“gender”** with a medical diagnosis of **“diagnosis”**.

Introductory statements from checklist

HISTORY/DIAGNOSIS:

*Secondary or tertiary diagnoses as relevant to mobility or seating
Height and weight*

CURRENT LIVING SITUATION:

Type of home, family/caretaker situation

HOW NEEDS MET TO DATE:

*Current equipment, why it does not meet current and future needs- age of current equipment
Progressive condition, lost ability to walk or propel any type of manual wheelchair
Reliance on other caregivers for mobility or self care*

MOBILITY:

*Not able to ambulate (never able or progressive condition)
Cannot propel any type of manual wheelchair for any functional distance
Transfer method
Hours per day in chair*

STRENGTH, FUNCTIONAL LEVEL AND ACTIVITIES OF DAILY LIVING (ADLs):

Important to list routine, time spent alone, independence in any self care

COGNITIVE ABILITY:

PREDOMINANT TONAL PATTERNS:

RESPIRATORY STATUS:

SENSATION, SKIN CONDITION:

*Risk of skin breakdown
Past history of breakdown*

VISION/HEARING:

GENERAL ENDURANCE/HEALTH:



Letter of Medical Necessity (LMN) Sample Template

PLANNED USE FOR WHEELCHAIR:

Home environment and accessibility
Outdoor environment and accessibility
Work environment
School environment
Social activities
Transportation
Goals

Assessment methods:

ROM assessment, mat eval
Seating simulation
Pressure mapping
Driver training
Home evaluation
Evaluation of family vehicle access, etc.
Etc.

EQUIPMENT TESTED:

Demo trial, success in maneuvering, other equipment tried, why it did not meet needs or expectations.

ESTIMATED TIME OF USE OF WHEELCHAIR: indefinite

Upon evaluation, the following equipment is prescribed for **:**

Batteries:

The above wheelchair prescription is medically necessary to meet "**Client**"'s medical and mobility needs. Thank you for your attention in this matter.

Sincerely,

Prescribing Physician

Date