Sample Letter of Medical Necessity

Date :

Re : *Patient Name*
ID # : *ins ID number*

To Whom It May Concern:

Patient Name is a ____ year old individual who suffers from left or right or bilateral sided hemiplegia or paraplegia due to an incomplete spinal cord injury at level _____ due to *****list trauma or surgery here********* . *Patient Name* has significant disruptions to their walking ability and walking potential. The inability of *Patient Name* to dorsiflex during ambulation has limited the ability to perform normal activities without fatigue due to inefficient gait pattern as a result of foot drop.

I have referred *Patient Name* to *Facility Name* for an evaluation for the WalkAide. The WalkAide is intended to allow for foot clearance and a more normalized, efficient gait pattern; thus lessening fatigue.
Some of the goals for *Patient Name* are listed below:

- Increase mobility and independence
- Increase safety during gait preventing falls due to better foot clearance
- Increase walking activities that can be performed
- Increase the ease and security of doing walking activities
- Decreases the need for personal assistance
- Dorsiflex the ankle at the optimum time during the gait cycle to improve limb clearance during swing
- Decrease energy expenditure/effort

In addition to the functional goals listed above, we hope to improve the ability and increase the ADL status of *Patient Name* to a more independent level. Based on my clinical evaluation and given the current medical condition, the WalkAide is the most appropriate treatment option for *Patient Name* . We are requesting authorization for the WalkAide.

Sincerely,

_____MD _____
Physician's Signature Date

_____
Print Physician's Name