

Sample Letter of Medical Necessity, #2
Assistive Device

Re:

MR#:

DOB:

Date:

To Whom It May Concern:

_____ is a four-year-old female with a diagnosis of Cerebral Palsy. Due to weakness and tone abnormalities, she is unable to safely ambulate without an assistive device.

An Up n'Free gait trainer by Easy Walking, with locking pins to lock rear wheels, has been prescribed which will provide appropriate assistance and will allow _____ to be as independent as possible during ambulation.

If you have any further questions, please contact me at _____

_____.

Sincerely,

_____, M.D.

_____, DPT, PCS, ATP