LETTER OF MEDICAL NECESSITY FOR OCCUPATIONAL THERAPY

Patient Name: _____ Date of Birth: _____

Insurance Provider: _____ Policy Number: _____

Treating Therapist Name: _____ Therapist Credentials: _____

Therapist License Number: _____

Diagnosis and Functional Limitations:

The patient presents with medical conditions that significantly impair their ability to perform activities of daily living, including but not limited to fine motor skills, sensory integration, cognitive processing, and functional mobility. These impairments impact the patient's ability to return to work or perform occupational tasks safely and effectively.

Medical Necessity Statement:

Occupational therapy is medically necessary for this patient to improve functional independence, reduce disability, and facilitate the highest possible level of occupational performance. The therapy plan is designed to address the patient's specific deficits and goals, including therapeutic activities to enhance strength, coordination, cognitive function, and adaptive skills.

Therapy Plan Overview:

Proposed occupational therapy will consist of a comprehensive evaluation followed by individualized treatment sessions focusing on areas such as upper extremity function, sensory modulation, cognitive rehabilitation, and activities of daily living training. The frequency is anticipated to be two to three times per week over a period of several months, subject to clinical progress.

Expected Outcomes:

With consistent occupational therapy services, the patient is expected to achieve improved fine motor coordination, enhanced cognitive processing, increased independence with daily living activities, and an overall improved ability to perform occupational roles and responsibilities.

Justification of Services:

These occupational therapy services are essential to prevent further functional decline, facilitate rehabilitation, and promote safe and effective participation in home, work, and community activities. Without therapy, the patient’s condition is likely to worsen or remain static, resulting in increased disability and reduced quality of life.

Duration and Frequency of Therapy:

The anticipated duration of therapy is approximately 12 weeks, with 2-3 sessions per week, each lasting 45-60 minutes. This schedule is subject to adjustment based on patient progress and clinical judgment.

Coordination of Care:

The therapist will coordinate care with the patient's primary care provider, specialists, and other healthcare professionals involved in the patient's treatment plan to ensure comprehensive and integrated care delivery.

Additional Comments:

Please consider this letter as formal documentation supporting the medical necessity of occupational therapy for the above-named patient. Should further information be required, please do not hesitate to contact the undersigned therapist.

THERAPIST SIGNATURE **PATIENT SIGNATURE**

Signature: _____ Signature: _____

Therapist Name: _____

License Number: _____

Office Address: _____

Contact Phone: _____

Email Address: _____