EmpowerRide Navigator

Letter of Medical Necessity Template (For Physician / PT / OT Completion)

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Height: _____ Weight: _____

Primary Diagnosis (ICD-10): _____

Secondary Diagnoses (if applicable): _____

PRESCRIBING PROVIDER INFORMATION

Provider Name: _____

Specialty: _____

Facility / Practice Name: _____

Phone: _____

NPI: _____

CLINICAL HISTORY & MEDICAL CONDITION

Describe the patient's medical condition, diagnosis, and functional limitations:

_____
_____
_____

Duration of condition: _____

Clinical progression: _____

Current treatment plan: _____

FUNCTIONAL LIMITATIONS

The patient demonstrates mobility limitations that interfere with daily living activities including:

- ☐ Sitting tolerance
- ☐ Postural control
- ☐ Safe transportation
- ☐ Community mobility
- ☐ Caregiver handling needs
- ☐ Medical equipment accommodation
- ☐ Positioning needs

Other: _____

Explain how the condition impacts daily activities:

_____
_____

PREVIOUS EQUIPMENT / INTERVENTIONS

List previous mobility devices or interventions and why they are insufficient:

- ☐ Standard stroller not appropriate
- ☐ Standard wheelchair insufficient
- ☐ Walker / cane ineffective
- ☐ Current equipment no longer meets needs
- ☐ Growth or condition change

Other: _____

Explanation:

_____
_____
_____

REQUESTED DEVICE

EmpowerRide Navigator Pediatric Medical Mobility Device

The Navigator is a clinically designed adaptive mobility device intended to provide medically necessary mobility support, improve positioning and postural stability, enhance safe transportation, accommodate medical equipment when required, and improve participation in activities of daily living.

MEDICAL JUSTIFICATION

- ☐ The requested device is medically necessary because:
- ☐ Patient requires specialized positioning support
- ☐ Patient requires caregiver-assisted mobility
- ☐ Standard devices do not meet clinical needs
- ☐ Device will improve safety and function
- ☐ Device will reduce caregiver strain
- ☐ Device will improve quality of life

Clinical justification:

_____
_____

EXPECTED OUTCOMES

Use of the Navigator is expected to improve functional mobility, increase safety during transport, provide appropriate postural support, reduce medical risk, and support participation in daily activities.

LENGTH OF NEED

- ☐ 6–12 months
- ☐ 1–3 years
- ☐ 5 years
- ☐ Lifetime

PROVIDER CERTIFICATION

I certify that this equipment is medically necessary and appropriate for this patient's condition and treatment plan.

Provider Signature: _____

Date: _____