



Letter of Medical Necessity (LMN)

For Sensory Regulation and Adaptive Equipment

Patient Name: _____

Date of Birth: _____

Parent/Guardian (if applicable): _____

Today's Date: _____

Provider Information

Provider Name (MD/DO/NP/PA/OT/Psychologist): _____

Practice Name: _____

Address: _____

Phone: _____

NPI Number: _____

Diagnosis & Clinical Need

- F84.0 Autism Spectrum Disorder
- F90.0–F90.9 ADHD
- F41.1 Generalized Anxiety Disorder
- R20.9 Sensory Processing Difficulties
- Other: _____

Clinical Symptoms Addressed

- Sensory seeking behavior
- Sensory over-responsivity/overload
- Poor self-regulation
- Attention difficulties

- Emotional dysregulation
- Anxiety/stress-related dysregulation
- Other: _____

Recommended Sensory Regulation Equipment

- Weighted vest
- Sensory chair
- Visual countdown timer
- Other: _____

Clinical Justification

The patient presents with significant sensory processing difficulties, poor emotional regulation, anxiety, and challenges with attention and transitions that substantially interfere with daily functioning, including self-care, learning, and social participation.

Additional justification (optional):

Treatment Duration

- 12 months Other: _____

Provider Certification

The above item(s) are medically necessary to improve sensory integration, reduce anxiety/overwhelm, support emotional/behavioral regulation, and enhance functional participation in daily living. This treatment plan complies with the definition of "**Medical Care**" under **IRS Code Section 213(d)**, and they are essential to manage the patient's diagnosed condition and reduce functional impairment. Less intensive interventions (e.g., verbal cues, standard seating, no weights) have been insufficient. I recommend these devices for use daily, at home and in community settings, for a period of 12 months from the date of signing.

Provider Signature: _____ Date: _____

Provider Printed Name: _____

Credentials: _____