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

☐ 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: _____