[Provider's Name, Title, and Credentials]
[Provider Contact Information]
[NPI and/or License Number]
[Practice Name and Address]
[Practice Contact Information]
[Date]

To Whom It May Concern:

Treatment:
I am writing this letter of medical necessity on behalf of my patient, **[Patient's Full Name]**, DOB: **[MM/DD/YYYY]**. [Patient's Name] has been diagnosed with **[Diagnosis and ICD-10 Code]**, a condition that significantly impacts their ability to travel independently and safely. I am recommending the approval of a **travel companion** to accompany [Patient's Name] during travel to and from **[specify location(s) or purpose of travel, e.g., medical treatment, family visit, educational program, etc.]**, for the duration of **[duration]**.

Clinical Rationale:
This accommodation is medically necessary because [Patient's Name]'s condition results in **[describe limitations—e.g., reduced mobility, sensory sensitivities, cognitive challenges, anxiety, need for medical monitoring, etc.]**, which pose substantial barriers to traveling alone. A qualified travel companion will provide essential assistance with **navigation, communication, medication management, emotional regulation, safety, and access to care or accommodations** during transit.

Without the presence of a travel companion, [Patient's Name] would be at increased risk for **[describe potential medical, behavioral, or safety risks—e.g., disorientation, falls, medical emergencies, heightened anxiety, or inability to manage adaptive equipment or personal care needs]**. This support aligns with best-practice standards for individuals with **[specific diagnosis or disability type]** and is consistent with [cite, if applicable, e.g., ADA guidance, clinical care recommendations, or functional assessment findings].

Relevant documentation—including medical records, specialist evaluations, and reports detailing [Patient's Name]'s functional needs—has been provided to substantiate the medical necessity of this accommodation.

Role of the Intervention:
The travel companion will serve as a medically necessary support to ensure [Patient's Name]'s **health, safety, and ability to access necessary services and environments** while traveling. Their role includes **assisting with communication, managing equipment or medication, preventing medical or behavioral crises, and providing supervision and physical support as needed**. This intervention enables the patient to participate in essential life activities that would otherwise be inaccessible due to their disability.

Conclusion:
In light of [Patient's Name]'s diagnosis, functional limitations, and the associated risks of independent travel, the presence of a travel companion is **medically necessary** to ensure safety, well-being, and equitable access to travel. I strongly recommend approval of this request as part of the patient's ongoing treatment and support plan.

Sincerely,
[Provider's Name, Title, and Credentials]
[Date]
[Signature]