**Re: Letter of Medical Necessity for the Levity Gait Trainer**

**Patient Name:**
**Date of Birth:**
**Insurance ID/Member Number:**

**To Who it May Concern,**

I am writing on behalf of my patient, *[name]*, who has been under my care since *[date]*. She has been diagnosed with *[diagnosis]* and experiences limitations in mobility, including *[add limitations]*

These impairments have an impact on her daily activities and overall quality of life.

After a comprehensive evaluation, I have determined that the use of an assistive device is essential to promote *[patient name]*'s mobility. I am specifically recommending the Levity gait trainer because:

- **Adjustable Support:** The Levity gait trainer offers an adjustable weight bearing option that promotes weight bearing and functional mobility.
- **Improved Mobility:** The device is lightweight and easy for the user to move.
- **Improved Posture:** Its design supports proper alignment.
- **Enhanced Participation and Interactions:** Being hands-free, the device allows the user to utilize their hands during daily activities, promoting greater participation in tasks and interactions with peers.

Given *[patient name]*'s medical history and current functional limitations, the Levity gait trainer is not only appropriate but medically necessary to prevent further deterioration of mobility. The device will play a vital role in her rehabilitation and ongoing management, facilitating greater independence and improved quality of life.

I respectfully request that *[insurance name]* approves coverage for the Levity gait trainer.

Sincerely,

_____-

[NAME], practice #